A Followup of

IMPLEMENTATION OF COMMISSION RECOMMENDATIONS TO IMPROVE MEDICAL CARE:

Craig Developmental Center

New York State
Commission on Quality of Care
for the Mentally Disabled

July 1982

Clarence J. Sundram
Chairman

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Commissioners

The New York State Commission on Quality of Care for the Mentally Disabled was designated by Governor Hugh L. Carey as New York State's Protection and Advocacy System for the Developmentally Disabled, pursuant to Public Law 94-103 as amended.

PREFACE

This review of medical care at Craig Developmental Center was undertaken by the Commission as an outgrowth of our long-standing concern over the quality of medical services available to residents of that facility. Our concern stems from investigations into deaths of residents of Craig Developmental Center conducted by the Commission and the Mental Hygiene Medical Review Board, as required by law.

On April 27, 1982, the Commission met with the then Acting Commissioner of the Office of Mental Retardation and Developmental Disabilities, Zygmond Slezak, and delivered a draft report of the findings, conclusions and recommendations emanating from this review. Subsequently, Mr. Slezak conducted a personal on-site inspection of Craig Developmental Center and received reports of internal staff reviews of operations at that facility, which were consistent with the Commission's findings.

On May 21, 1982, Mr. Slezak announced the replacement of the Director of Craig DDSO and the Deputy Director of Treatment Services, the retirement of the Deputy Director of Health Services and the suspension and service of disciplinary charges upon the Chief Pathologist.

The response of the Office of Mental Retardation and Developmental Disabilities to the recommendations made by the Commission are included following each recommendation. The Commission will monitor the implementation of these recommendations.

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TABLE OF CONTENTS

INTRODUCTION

In the course of its ongoing function of investigating deaths of patients and residents of mental hygiene facilities, the New York State Commission on Quality of Care for the Mentally Disabled (CQCMD) and its Mental Hygiene Medical Review Board (MRB)* have had occasion to issue three formal reports describing serious inadequacies in the medical care afforded to the deceased residents of Craig Developmental Center (CDC).

On November 24, 1980, the Commission wrote to the Commissioner of the Office of Mental Retardation and Developmental Disabilities (OMRDD) that, "we believe there is a special need for attention to the serious deficiencies in the quality of medical care provided to the residents of Craig Developmental Center.... We are concerned about the capability of the Peterson Unit to provide quality acute medical care. We strongly recommend that your office retain outside, independent medical consultation to review the quality of medical care to residents at Craig Developmental Center and to make recommendations to ensure the future care and safety of Craig residents."

In response to this recommendation, as well as public reports of dissatisfaction of nursing staff at Craig with working conditions, OMRDD convened a "Craig Technical Assistance Project" (CTAP) to examine a variety of aspects of Craig's operations. The CTAP prepared a report dated May 6, 1981 containing its findings and recommendations. The implementation of these recommendations was to be the joint responsibility of Craig, the County Service Group and Central Office of OMRDD.

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*The Mental Hygiene Medical Review Board is a statutory component of the Commission responsible for reviewing unnatural or unusual deaths of patients of mental hygiene facilities.

A Medical Advisory Committee composed of physicians from the community was also appointed as recommended by the Commission.

In the fall of 1981, as the Commission initiated an investigation into the circumstances surrounding the death of yet another Craig resident,* Commission staff received complaints regarding medical care at the facility from both parents of residents there and staff of the Mental Health Information Service. Many of the complaints echoed concerns expressed by the Commission in its previous reports. As such, while the Commission continued its investigations into the deaths of 13 particular residents of the Center, it initiated a broader review to determine the extent to which previous recommendations to upgrade and monitor medical care had been implemented.

It should be noted that the Commission has no statutory enforcement powers. If recommendations made by the Commission are not implemented, our primary recourse is to report these findings to the Commissioner, the Governor and the Legislature, and to the public. Thus, the Commission periodically conducts follow-up surveys to ascertain the status of implementation of recommendations previously made by the Commission and accepted by the facility.

In this endeavor, the records of 15 patients of Craig's infirmary--the Peterson Unit--were reviewed. Additionally, senior administrators and medical, nursing and direct care staff were interviewed.

The subsequent chapters of this report detail the record of Craig and the OMRDD to effectively implement recommendations to assure that residents of Craig receive appropriate medical care.

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*Currently the Commission is investigating the deaths of 13 residents of Craig Developmental Center.

CHAPTER I

Upgrading Medical Services

The Implementation of Commission Recommendations

Following the review of the deaths of Joseph C. and Alice S., the Commission's Medical Review Board (MRB) issued a number of recommendations to upgrade the caliber of medical services afforded Craig Developmental Center's (CDC) residents.[1] Specifically, it was recommended that:

- Craig Developmental Center should reassess and define the role of their medical unit, Peterson. The functioning of this unit as an infirmary providing nursing care and convalescent care rather than an acute care hospital should be clearly stated and conveyed to community hospitals and consultative practitioners.

- Craig should negotiate with Noyes Memorial Hospital regarding clients undergoing general surgery to assure that all surgical cases are afforded a reasonable postoperative period of recovery and observation in the general hospital as would any patient admitted from the community. In those cases involving severely aggressive or unmanageable clients, Craig should provide assistance to Noyes during the period of hospitalization.

- Recognizing that the Peterson Unit is not an acute care hospital, physicians should be urged to seek hospital consultation promptly rather than delaying until the patient is moribund.

- Clients deemed ill enough to be sent to an emergency room by a Craig Developmental Center physician should be afforded an evaluation visit reasonably promptly and by the CDC physician in cases when the hospital sends the clients back to CDC. At such time, the physician should reassess the patient, review the emergency room record and write appropriate medical orders.

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[1] In the Matter of Alice S., A Resident of Craig Developmental Center, July 1980; and, In the Matter of Joseph C., A Resident of Craig Developmental Center.

- In an effort to increase communication between community and facility physicians, a transfer form should be developed by CDC for use when sending clients to outside facilities and practitioners. This form should include pertinent information about the client, as well as a section wherein the consulting physician can write his/her impressions and recommendations for care.

- CDC should develop and implement a mechanism to assure the transfer of patient information from physician to physician when going off duty or at end of tour.

OMRDD and CDC agreed to implement these recommendations and, following the release of a third Commission report which cited continuing serious deficiencies in medical care, Craig further stated that it would reorganize and reassign its medical staff.

The Commission's follow-up review activities at Craig indicate that although Craig has reorganized its medical staff and established a "primary physician model of care,"[2] the role of the Peterson unit, as an acute care facility, has changed little and that care there continues to be less than adequate.

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[2]The primary physician model of care was intended to afford Craig' residents greater continuity in care.

Prior to the spring of 1981, physicians were assigned to clients on a geographic basis; that is, they were assigned to clients within particular buildings. For example, the Peterson Unit had one physician assigned to provide care for the Unit's residents. To ensure a continuity of care as clients moved from building to building, the geographic assignment of physicians was abandoned in favor of a system of client-specific assignments.

Under this "primary physician model of care", each physician was assigned specific clients and would provide medical care for these clients whether they remained in one living unit or were transferred elsewhere in the facility.

Specifically, it was found that:

1. There is considerable confusion among the medical and nursing staff concerning the level of care to be provided in the Peterson Unit.

For example, when four Craig physicians were questioned regarding the level of care provided in the unit, one responded that it was an infirmary providing essentially nursing care; another responded that it was an acute care facility; and still another indicated that it treats whomever is sent there until treatment can no longer be provided. And in a letter to a client's family, dated February 11, 1982, it was found that the physician informed the family that the patient had been admitted to "our acute medical/surgical unit." [Emphasis ours.]

At the time of the Commission's follow-up review, the Unit had no written admission or discharge criteria to clearly define the type of care to be provided there. Nurses at the Peterson Unit also indicated that at times the Unit is utilized as an acute care facility and, while they feel they have the necessary skills to provide this level of care, they voiced concern over the lack of resources to deal with acute medical problems.

Confusion over the role of Peterson Unit may also have been compounded by the fact that last fall all the therapy aides assigned to the Unit were reassigned to residential units and replaced by nursing personnel. At a time when the role of Peterson as an infirmary, and not an acute care facility, should have been stressed, staffing the Unit with entirely medical personnel could naturally lead to confusion.

2. The Peterson Unit continues to be used as an acute care facility providing care to patients returned prematurely from community hospitals.

During visits to the Peterson Unit, Commission staff reviewed the records of nine patients who were treated at community hospitals and returned to the Peterson Unit. In the opinion of Commission staff and Peterson nursing staff, two of these were returned prematurely and were in need of a higher level of care. One of the patients was returned from Noyes Hospital within hours of her surgery for a femoral head-neck resection; the other was returned in an orthopedic device never before seen by the nursing staff at Peterson. As such, the nurses claimed that they were unfamiliar with the care required by this patient. The return of such patients to Craig Developmental Center without an adequate period of postoperative recovery at a hospital where they can be closely monitored by the surgeon has previously been criticized by the Commission and Medical Review Board.[3]

3. Despite the creation of a Primary Physician model of care, Commission staff found significant deficiencies in the attentiveness of physicians to patients in the Peterson Unit. Records reviewed indicated that continuity of care has not been enhanced by this initiative.

In reviewing the cases of 15 patients in the Peterson Unit, the Commission found significant gaps in physican progress notes in five cases or one-third of the total sample. Gaps in progress notes varied from 5 to 14 days.

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[3] In the Matter of Alice S., A Resident of Craig Developmental Center, July 1980.

For example, in the case of a patient who was admitted to Peterson from his residential unit and was cyanotic and bleeding rectally at the time of his admission, there were no physician progress notes for the first five days of his stay at Peterson.

In another case, a patient had returned to the Peterson Unit following surgery at a community hospital for a fractured leg. In the two weeks following her return to the Unit, there were no notes by the patient's primary physician. The only physician note was written by an on-call physician, indicating that the patient had returned from the community hospital and that previously written physician's orders would resume.

Some of the potential complications which can arise in the lack of consistent attentiveness to patients needs are illustrated in two cases.

A male patient was admitted to a local hospital with the diagnosis of intestinal obstruction with jaundice in Jaunary 1982. In reviewing the precipitating reasons for this patient's transfer to the Peterson Unit and eventually to the community hospital, Commission staff relied on nursing program notes, due to the lack of physician documentation.

Beginning two days before the patient's transfer to the hospital, an aide recorded that the patient had stomach pain and was not eating. The on-call physician was notified and ordered, by telephone, a Fleets enema and milk of magnesia. The aide recorded giving an enema "with poor results."

The following day, the nurse recorded continued pain and "abdomen distended." The evening nurse recorded the same, along with a fever of 102 degrees. The on-call physician was called and, again by phone, ordered Tylenol,

another enema and a rectal exam. The nurse followed through, but with "poor" results. The nurse administrator was called, performed a second rectal exam and re-called the on-call physician. The physician ordered, by telephone, another enema, manual removal of the impaction, ampicillan and milk of magnesia. The nurse recorded that a cantalope sized impaction was removed. The patient was recorded as vomiting.

The nurse reported the above to the on-call physician who verbally ordered transfer to the Peterson Unit, again by telephone.

Upon admission to Peterson, the patient was not seen by a physician. Telephone orders by the treating physician authorized the Peterson nurses to start an intravenous and to withhold all oral feedings and medications except Talwin for pain. (Ordering of pain medications without examination of the patient was criticized by the MRB as a poor practice as it masks the symptoms.)[4] The Peterson Unit nurses recorded that the patient continued to have abdominal distention and that he was jaundiced (Living Unit nurses had not previously noted this). As a further sign of deterioration, the night nurse noted that although the patient had been given 600cc of intravenous fluid, he had excreted only 100cc of dark urine. His fever continued.

Two days after his symptoms began, the patient was finally seen by a physician, who then immediately ordered an x-ray of the chest, abdomen, an NG tube, blood tests, and transfer to a community hospital.

Proof of the patient's precarious position when admitted to the community hospital is the admitting note which states "possible surgery...even tonite." The community

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[4] In the Matter of Joseph C., A Resident of Craig Developmental Center, August 1980.

physician noted, "has been vomiting two days, jaundiced two days." This is not evident in Craig's records. Further, the local physician noted, "mass is felt in right upper quadrant." There is no mention of this in Craig notes.

In summary, it appears that this patient was not seen in a timely fashion by the on-call physician and was treated repeatedly by telephone orders which, no doubt, prolonged his suffering. After two days of this suffering, the patient was transferred to a local hospital where immediate surgical intervention was initiated. Following a month-long stay at the local hospital, the patient's condition improved, and he was discharged back to Craig.

The second case which illustrates the failure of the primary physician concept to enhance continuity of medical care at Craig involves a Peterson Unit patient being treated for cancer at a local hospital. In this case, during the patient's 43 day stay at Peterson following treatment at an outside hospital, the primary physician entered no progress notes. The only progress notes in the record to describe the patient's condition were those of the community physician. Medication orders for this patient were signed by four different physicians on five different occasions.

Additionally, none of the physicians followed through on the community physician's recommendation that "the FBS (fasting blood sugar) should be followed very carefully now that cortisone has been stopped...insulin requirement will decrease." The community physician also urged weekly CBC's.

Fortunately, a nurse at Peterson had taken it upon herself to draw this patient's blood and send it for testing because, as she reported, it was clear based on the report of the community hospital and its physicians that the patient required the tests and she could not get the patient's primary physician at Craig to follow through on the recommendations of the community physician.

4. Since the primary physician model of care has been introduced, considerable confusion has developed among medical staff surrounding the reasons for its implementation, its overall effectiveness and the appropriate role for physician assistants in the mainstream of medical care.

A number of physicians interviewed believed that the Commission mandated the reorganization to the primary physician model, when in fact, such was not the case. (It should be noted that CDC physicians had never seen the Commission's reports or recommendations.) They resented not having been consulted in this decision and are of the opinion that by assigning each physician the responsibility for total care for groups of clients, the Center and the clients are failing to capitalize on particular physicians' areas of expertise.

Virtually all treatment staff interviewed held negative reactions to the primary physician care model. Staff noted that frequent transfers of clients from one living unit to another has made the primary physican concept even more confusing. In one unit, patients of five different physicians were living together. When situations such as this occur, staff deal with it by ignoring the primary physician and having all standing orders reviewed by the phsycian who is either in closest proximity, or who has the greatest number of clients on the unit.

After our record review, Commission staff found that often it is difficult to ascertain who is the primary physician due to the number of different signatures found in the progress notes and physician order sheets.

Compounding the problems of the primary physician model of care is the lack of a clearly defined role for physician assistants (PAs). The Commission's review indicated that physician assistants are assuming a greater role in the medical care of Craig residents. However, while physicians are assigned to specific clients, PAs are assigned geographically. As such, some PAs relate to as many as six different physicians. Furthermore, while assuming a greater role in hands-on medical care, PAs have not been fully assimilated in the medical community at Craig. For example, they have only recently been invited to attend medical staff meetings and have not yet been invited to attend Mortality Review Committee meetings.

A Commission review of a Craig resident's death in January 1982 illustrates the increasing, but poorly defined, role of PAs in providing medical care to Craig residents. In the Commission review of this case, it was noted that there was not a single entry by a physician in the record for a two-year period. All progress notes were written by a physician assistant. Additionally, the client's service plan was not signed by a phsyician. Monthly orders for this patient were signed by a physician, although they were written by a nurse and no additional notes were written by the physician. The last two annual physical exams were completed by physician assistants. In the end, while PAs provided virtually all of this resident's medical care, they were not included in the facility's review of circumstances surrounding his death.

While the Commission welcomes the utilization of physician assistants to help meet client needs, it is clear that their role has not been adequately defined despite their increasing resonsibilities. It is equally clear that the responsibilities of physicians for supervision of PA's needs further definition.

5. Although it was recommended that Craig physicians seek hospital consultations promptly for acutely ill patients, several recent cases tend to indicate that this is not being done in a consistent manner.

The Medical Review Board's most recent review of a death of a Craig resident indicated that rather than sending the client for a consultation at a community hospital, the Craig physician attempted to treat the patient at Peterson which was ill-equipped for both the evaluation workup and medical treatment which was ordered. This same lack of timely referrals for consultations and treatment was also evident in two cases reviewed during the Commission's follow-up activities.

In the first case, a patient was treated for pneumonia in the Peterson Unit for a full two months before being transferred to a community hospital. Since there was no Craig physician order for culture and sensitivity studies to determine the actual organism causing the lung infection, treatment with antibiotics varied from Ampicillan to Ceclor. When both antibiotics continually failed to treat the problem, the patient was transferred to a local hospital.

By the time he was transferred, the patient had developed edema of the lower extremeties, a possible fluid imbalance and a urinary tract infection (undetected at Craig). Medical staff at the local hospital noted that this patient was "malnourished and emaciated" upon admission. He was treated with a different antibiotic, Keflin, and also Septra for the urinary tract infection, and released after 12 days.

The second case illustrates not only the lack of timely referrals, but also the inattentiveness of Craig physicians to patients' conditions. In this case the client, a 60-year-old man, was struck in the mouth by another client on September 6, 1981, and knocked unconscious for 15 minutes.

The primary physician was called immediately, examined the patient at 10:20 a.m. and ordered bedrest, checking of vital signs for 24 hours, and skull x-ray "whenever available."

At 11:20 a.m., the resident began to appear disoriented; nurses were unable to keep him in bed and he began to vomit blood, mucus, and other matter.

At 12:15 p.m., his condition persisted. He was transferred to the Peterson Unit. At 12:50 p.m., he was admitted to the Peterson Unit, via stretcher; semi-conscious. He was examined by the same physician as above upon admission. His response was dull, he had no use of his right arm and he was bleeding from the mouth.

From 1:00 p.m. that day until 12:45 p.m. the next day, a full 24-hour period, his condition deteriorated. The patient began drooling, showed signs of lethargy, was difficult to arouse and was unable to move his right arm. His left pupil reacted only slightly to light and his right demonstrated no reaction.

By 12:45 p.m. the next day, as noted by a nurse, the patient's only movement was raising his left hand to his face. At that point, he was transferred to Strong Memorial Hospital. Upon arrival to Strong Memorial, a CAT Scan was completed and showed a large left epidural hematoma in the frontal and temporal area and an intra cerebral hematoma in the arterior left temporal region. That same day, through surgical intervention, the hematoma was removed from the epidural space, the brain was incised, and the clot removed from within the anterior and medial left temporal lobe.

Despite obvious symptoms of major neurological trauma, the patient was seen only once by a physician on arrival to the Peterson Unit at 1:00 p.m. on September 6, 1981. He was

not seen again until 10:30 the next morning by a second physician, who did not record his findings. Even after that examination, he was not transferred to a community hospital for at least two and one-half hours.

In a report from Strong Memorial Hospital where the patient was treated and released three weeks later, it was stated, "When seen here, patient was comatose...eyes were deviated to the left.... There was a contusion of the scalp on the left side. A profound hemipelegia involving the face, arm and leg...diffused Rhonchi and labored breathing."

His final disposition by Strong Memorial was:

a. Fractured skull;
b. Epidural Hematoma - left, frontal and temporal;
c. Intracerebral Hematoma - left temporal lobe;
d. Pneumonia;
e. Atelectasis; and,
f. Klebella Pneumonia.

It is difficult to comprehend how conditions as serious as these were not noted by medical staff at Craig, and attended to more promptly.

6. Although recommended in the summer of 1980, Craig did not, until the Commission initiated its review of earlier recommendations, develop a transfer form to transmit pertinent client information when sending patients to community hospitals.

In November 1981, when Commission staff sought to examine the transfer form reportedly developed by Craig, it was found that no such form was being utilized. Rather, nursing staff reported that transfer forms developed by four out of the six hospitals to which Craig refers patients were used when referring patients to these hospitals. In the

case of the remaining two hospitals, in lieu of a transfer form, the patient's entire case record was sent at the time of transfer.

It should also be noted that Commission staff found a number of inconsistent responses on the part of Craig staff regarding the methods employed in transferring clients to community hospitals.

Upon a return visit to the facility in January 1982, Commission staff again found varying responses regarding methods of transferring clients. However, at that time a new nursing procedure had been developed which included a transfer form and which communicated methods of transfer to staff in a more consistent manner.

7. As reported by Craig, in an effort to improve communication among medical staff, at the change of shifts, most physicians are now reading and signing the nurses' log when they come on duty.

However, one physician who works on a full-time basis, but provides weekend coverage only, consistently does not communicate with the nursing office. Staff indicated that another full-time physician rarely signed this log.

Craig has thus, to a certain degree, initiated a system to increase communications among the physicians between shifts. However, the value of such a system is questionable when it is not utilized consistently.

The Impact of the Craig Technical Assistance Project

In the Spring of 1981, the OMRDD directed Central Office staff to conduct an outside review of critical issues at Craig. This initiative was prompted by the Commission's findings concerning the deaths of Joseph C. and Alice S.,

and reports received from Craig staff who alleged that the quality of care at the facility was deteriorating. The OMRDD was also aware of the Commission's plans to release a third report concerning the circumstances surrounding the death of another Craig resident, Frank Darby[5] (a pseudonym). The OMRDD's "Craig Technical Assistance Project" (CTAP) was undertaken to provide an impartial review of key issues at Craig, including medical services, and to obtain a baseline of information for future intervention. It was anticipated that the responsibility for implementing recommendations stemming from the review would be shared by Craig, the County Service Group and Central Office.

In following-up on the implementation of recommendations contained in the Joseph C., Alice S. and Frank Darby reports, Commission staff also reviewed the impact which the "Craig Technical Assistance Project" had on upgrading medical services. Generally, it was found that although the CTAP was prompted by the findings disclosed in Commission reports, the CTAP did not facilitate the implementation of recommendations contained in those reports. In fact, it appears that the CTAP had little impact on upgrading medical care at the facility.

Specifically, it was found that:

1. In certain instances, the CTAP offered no recommendations to remedy identified problems and in other instances the recommendations offered were unrealistic.

For example, the CTAP touched upon concerns of nursing staff such as: out of title work; involuntary overtime; reduction of nursing staff coverage in residential units;

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[5] In the Matter of Frank Darby, A Resident of Craig Developmental Center, August 1981.

and lines of supervision. Yet, no resolution was suggested and no recommendations offered.

Visits by Commission staff in January and February 1982 affirm that these problems continue to remain unresolved according to the CDC staff interviewed.

Similarly, the CTAP report states that "it is startling to note that no planning conference has taken place between the DDTS (Deputy Director for Treatment Services) and the Chief of Medical Staff, " yet the report offered no recommendations to bridge this apparent communication gap. In fact, Commission staff found that, perhaps from the onset, lines of comunication may have been blurred. The CTAP identified the pathologist as Craig's Chief of Medical Staff and reported that all physicians and consultants report to him and he to the Facility Director. In January 1982, the Facility Director at the time of the CTAP who is currently the Facility's Deputy Director for Health Services, informed medical staff that she had told the pathologist not to use the elective title although he had done so for a number of years.

In another instance, the recommendation by the CTAP was, in the opinion of Craig staff, unrealistic. Noting a shortage of 163 therapy aide staff on certain shifts, yet an excess of 20 food service staff, the CTAP recommended transitioning excess food service staff to therapy aide positions. In interviews with Commission staff, Craig's Deputy Director for Treatment Services reported that this was an unrealistic recommendation. She indicated that although staff could be encouraged to make the transition, they could not be coerced to do so.

2. <u>The nature of other suggestions or recommendations stemming from the CTAP, or the process of their implementation, have not ameliorated problems at Craig and may have in fact exacerbated some</u>.

The CTAP identified a major rift between the non-medical and medical staff (including nursing) at Craig and reported that the "mutual hostility" between these two communities manifested itself in a number of ways including minimal input from physicians in treatment and discharge planning. In short, the CTAP found that "physicians are far from being integrated in (the) interdisciplinary team." The CTAP report also indicated that the physicians felt as if they were not trusted.

As an outgrowth of the CTAP, there was a major reorganization of Craig's administration: a new non-medical professional was recruited to serve as the Facility's Director, and Craig's former Director assumed the role of Deputy Director for Health Services (DDHS)--a newly created position within the administrative structure. One standard for the DDHS' effectiveness, as indicated in the CTAP report, was that medical plans were to be actively incorporated into the interdisciplinary plan and freely transmitted to necessary staff.

While the integration of medical aspects of care into the total care plan of Craig residents may have been an objective in the reorganization of Craig and was certainly an indicator of the effectiveness of the newly created DDHS position, the Commission's review indicated considerable confusion over the role of the DDHS and a resulting widening of the gap between medical and non-medical staff at even the highest level of Craig's administration. For example, in interviews with Commission staff, the DDHS indicated that she reports to County Service Group and Central Office staff, and that only the Associate Commissioner of the County Service Group is responsible for evaluating her performance. The Facility Director, on the other hand, indicated that the Deputy Director of Health Services reports directly to him.

The confusion over leadership for health-related matters at Craig was compounded during the implementation of the new administrative reorganization. In the draft role description of the DDHS appended to the CTAP report, it states that the DDHS will provide ongoing medical leadership for Craig and its community programs. However, during the Commission's followup, it was found that nursing personnel report to the Deputy Director for Treatment Services. This supervisory structure at times leads to bizarre situations. For example, the Peterson Unit, which is intended to serve as Craig's infirmary, should naturally serve Craig's most medically involved residents and require strong medical leadership. Yet, its staff--all nurses--report not to the Deputy Director for Health Services, but to the Deputy Director for Treatment Services, and decisions on staffing patterns and levels for the Unit are in the hands of the DDTS.

3. Craig, the County Service Group, and the Central Office failed in their joint responsibility of implementing the recommendations of the CTAP and, as such, problems identified by the CTAP persist.

As indicated previously, the CTAP revealed a number of problems at Craig including the rift between the medical and non-medical communities, the lack of medical input into treatment and discharge planning and the sense of mistrust on the part of the physicians. While the CTAP offered suggestions for correcting these problems, Commission staff, in their followup review, found conditions relatively unchanged--an indicator of the failure of the various OMRDD administrative units to effectively implement and monitor CTAP recommendations.

For example, with regard to treatment and discharge planning, Commission staff interviewed three Craig physicians to determine the level of their participation. Below are their responses to the questions:

- Do you attend meetings preparatory to placing clients in the community?

  Dr. A.: "No, I just do the physicals before they go, and sign the sheet."

  Dr. B.: "Yes, sometimes."
  Dr. C.: "No, we doctors just do the physicals and sign off."

- Have you ever objected to placement...what occurred?

  Dr. A.: No response.

  Dr. B.: "No, I've never objected...that's bad, isn't it?"

  Dr. C.: "Yes, I've objected to placement several times, more than once, my objection was removed from the chart. I don't care any more."

- Do you participate in multidisciplinary treatment meetings?

  Dr. A.: "No."

  Dr. B.: "Yes -- on their birthday."

  Dr. C.: "No."

In their interviews, Commission staff also found that the rift between medical and non-medical staff and the sense of mistrust on the part of physicians persisted. In fact, not only have they persisted, but they have reached unhealthy proportions as indicated in a recent statement contained in the minutes of the Mortality Review Committee meeting of March 8, 1982. These minutes state: "the feeling was voiced that institution physicians are apparently not trusted, especially if they are not native born. The feeling was also expressed that 'we are first rate, licensed physicians and some of us are white.'"

CHAPTER II
Monitoring Medical Services

In reviewing the deaths of Craig residents, the Commission recognized the need for ongoing monitoring of medical services at the facility and recommended the creation of external and internal monitoring and review mechanisms.

The Medical Advisory Board

In concluding its third report on a Craig resident's death, the Commission's MRB recommended that the Office of Mental Retardation and Developmental Disabilities retain outside, independent consultation to review the quality of medical care available to residents of Craig Developmental Center.

In response to this recommendation the OMRDD indicated that a Medical Advisory Board, consisting of physicians representing the medical society, the University of Rochester School of Medicine and various specialties, had been appointed to review the quality of medical care at Craig. In following up the MRB's recommendations, Commission staff generally found that due to the manner in which it is presently organized, this Medical Advisory Board (MAB) has failed to serve as an effective vehicle for the independent review of the medical care at Craig. This general finding is based on interviews with senior Craig administrators, medical staff and a review of Board meeting minutes of the past year.

Specifically, it was found that:

1. The Board's ability to provide an independent review of medical care is hampered by the fact that Craig's former Director and current Deputy Director for Health Services creates the agenda, thereby screening the matters coming to the Board's attention.

In interviews with Commission staff, the DDHS explained that she creates the agenda for the Board meetings and brings to the Board's attention matters which, in her opinion, warrant discussion. Board members do not routinely receive and review internal Craig reports which may suggest areas of concern--reports such as those of the Incident Review, Mortality Review, or Infection Control committees. Nor do Board members review records of clients (either on a sample basis or special interest basis). Rather, the only materials routinely received in recent months by the Board have been the QCC 100 death reporting forms. The DDHS explained, however, that the Board could receive and review any materials it requested. However, as noted in the following section, at least one such request was not acted on.

Illustrative of the compromising impact of the DDHS' control over the MAB agenda is the case of the 60-year-old man who, as described in the first chapter, was punched in the mouth and treated at Strong Memorial Hospital. Following reviews by the Facility's Special Review Committees and the Mental Health Information Service, and recommendations that this case be reviewed by a group with medical expertise, the DDHS investigated the incident and indicated in her summary report that the case would be presented to the MAB at its January 1982 meeting. However, the minutes of that meeting indicate that the case was not discussed.

It should be further noted that the Board has only once met at Craig and its members have rarely, if ever, toured the medical services areas of Craig.

2. The Board's ability is further impaired by the fact that the DDHS screens its recommendations and takes action on only those she deems appropriate.

At the April 23, 1981 meeting of the Board, there was a discussion of the "real or perceived" early return of clients to Craig following surgery at local hospitals. At this meeting it was recommended that the Board continue its discussion at its next meeting and that the DDHS provide representative records for review. As subsequent meeting minutes contained no reference to this recommendation, the DDHS was questioned by Commission staff as to the status of the April 23 recommendation. She indicated that she decided not to act upon the Advisory Board's recommendation as the topic of premature returns from hospitals had already been resolved and that the physicians might be predisposed to criticizing local hospitals without having all the facts. In the end, the Advisory Board did not have an opportunity to review the representative records, gather any facts and offer its impartial opinion. (As indicated in the first chapter of this report, Commission staff found that patients are still returned prematurely to the Peterson Unit following surgery at community hospitals.)

As an example of a MAB recommendation which was followed up, the DDHS offered the recommendation issued during the June 1981 meeting of the Board. At that meeting, it was recommended that the facility establish a "serious internal review mechanism" and that medical staff assess each client death prior to reviews by non-medical staff. At its October meeting, the DDHS reported to the Board that the facility's pathologist had been made responsible to convene staff and discuss issues of medical care at the facility. However, this is essentially the same response she, as Facility Director at the time, offered the Commission in July 1980, when the Commission recommended the establishment of a

process whereby, upon the unanticipated demise of a client, all staff involved, at all levels, exchange information, identify problems, and plan corrective interventions.

In actuality, the review mechanism which the DDHS described to the MAB in October 1981, and the Commission in July 1980, is the Mortality Review Committee--a long-standing committee at Craig. Its effectiveness as "a serious internal review mechanism" is addressed later in this report.

3. After nearly one year of operation, the composition of the Board is insufficient and attendance at meetings is poor.

In reviewing the minutes of the Board's March, April, June and October 1981 meetings, it was found that, at most, only two physicians independent of Craig, attended the meetings and the October meeting was attended by only one independent physician. Furthermore, it was found that only one independent physician attended three consecutive meetings and that attendance had fallen off to the point that neither of the only two independent physicians who attended the first two meetings of the Board attended its fourth meeting. The poor fluctuating attendance at meetings raises serious questions regarding the Board's ability to enter into meaningful and continuing dialogue over the problems plaguing Craig and to offer constructive advice.

4. The MAB has failed to make any significant impact on medical staff or the facility's director.

In interviews with Commission staff, the facility director (who reportedly receives copies of MAB meetings)

could not answer any questions concerning the functioning of the Board. Rather, he referred all questions to the DDHS. Similarly, three physicians who attended the April meeting of the MAB were asked if the Board has helped them or if they perceive it as a peer review mechanism. None of the physicians questioned knew the nature of this Board.

The Mortality Review Committee

Citing the need for thorough investigations of unanticipated deaths and planned interventions to prevent their reoccurrence, the Commission recommended that a mechanism for review of unanticipated deaths be established and that this process of problem identification and planned intervention include the input of staff at all levels.[6] Craig responded that the facility's Mortality Review Committee, chaired by a pathologist, would serve this function.

The Commission's follow-up activities indicate that Craig has not implemented the Commission's recommendation and that there exists no process for involving all levels of staff in problem identification and the planning of interventions to prevent the reoccurrence of deaths. Specifically, it was found that:

1. The Mortality Review Committee, until January 1982, failed to discuss non-medical aspects of care and failed to make recommendations to prevent future deaths.

In interviews with Commission staff in November and December, the Mortality Review Committee's (MRC) Chairman,

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[6] In the Matter of Joseph C., A Resident of Craig Developmental Center, August 1980.

Craig's pathologist, indicated that the Committee is comprised of only physicians and reviews only medical aspects of care to arrive at a general consensus on the cause of death. The pathologist, when questioned about the fact that the minutes of the Committee meetings contained no recommendations, indicated that the Committee offers no recommendations as he feels it is not qualified to do so.

2. Since January 1982, a change in the Committee's leadership has brought a new focus to the Committee's meetings and the Committee is beginning to offer recommendations.

In January 1982, the MRC experienced a change in leadership with the DDHS assuming the chairmanship of the Committee. According to the DDHS, Craig's pathologist was removed from the position. According to the pathologist, he offered his resignation because he was receiving pressure to alter and/or downplay certain findings of autopsy reports which would be considered in determining the cause of death.

Since the change in leadership, although the Committee is still comprised of only physicians, the meeting minutes reflect consideration of non-medical aspects of care. Additionally, the minutes indicate that recommendations are being posited. However, the minutes do not indicate any assignment of responsibility to ensure that recommendations are communicated, implemented and monitored. For example, during the Mortality Review Committee discussion of a patient who died in January 1982, three different physicians were quoted in the minutes as criticizing both the placement and case management of this resident. Yet, the Unit Chief, who has direct responsibility for the care of this resident, had never seen the minutes and has no knowledge that these issues were raised.

In short, although there has been recent[7] improvement in the functioning of the MRC, this Committee still does not provide the opportunity to ensure the input of all levels of staff in identifying problems and corrective actions to lead to the avoidance of future unanticipated deaths. As indicated in a Commission investigation into a recent client death, the Mortality Review Committee does not even ensure that the primary treating physician attends the review of his or her own patient's death.

3. The absence of information sharing among standing review committees at Craig further inhibits a process of ensuring the prevention of unavoidable deaths.

While the Mortality Review Committee has historically avoided, in its composition and deliberations, non-medical aspects of care, the facility's Special Review Committee, which is responsible for the review of all incidents and the investigation of all major incidents including deaths of inpatients, sudden or accidental, has avoided reviews of medical aspects of care involving incidents of death. While both committees may review the same case from differing perspectives, neither committee shares with the other the findings or recommendations of its deliberations. In fact, it was found in interviews with the Chairman of the Special Review Committee that the Committee reviews only some deaths and only some incidents and that the Chairman is

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[7]It should be noted that this change in the operations of the MRC was initiated when the Commission commenced its review of recommendations stemming from earlier investigations--nearly 16 months after the Commission first recommended the need for an internal review mechanism to prevent the recurrence of unanticipated deaths and seven months after the MAB made a similar recommendation.

unsure as to why only certain deaths are referred for review by his Committee. He indicated that the Deputy Director for Treatment Services screens all incident reports and only refers certain incidents for Committee review--an apparent violation of OMRDD policies.

The SRC reviews only those incidents which are sent to it by the DDTS. The Chairman does not know what criteria is used to screen out incidents, or what proportion of the total number of incidents the Committee reviews.

Although the Chairman feels it might be useful at some point, currently there is no attempt made to compile statistics on major or minor incidents for comparison among units, shifts, or days. There is no mechanism to insure administrative follow up on any of the few recommendations made. For the most part, the "minutes" of these Special Review Committee meetings consist only of a list of client names and a one-word designation of the issue, (e.g., "death," "injury") and do not contain any data regarding the content of the review.

CHAPTER III

Conclusions and Recommendations

It is apparent from the findings that the poor medical care afforded to Craig residents, reported two years ago by the Commission, continues. There continues to be a widespread misconception among physicians and staff about the capabilities of the Peterson Unit and it continues to receive patients in need of acute hospital care that it is incapable of providing. As a result, there continue to be unnecessary, and occasionally life-threatening, delays in transferring patients to acute care hospitals. The physicians' attentiveness to patients' needs has not improved and the problem of lack of continuity of care appears to have become worse.

What emerges from our ongoing review of medical care afforded to residents of Craig Developmental Center, as well as of the modus operandi of this facility, is that there appears to be a strong resistance to change by the medical leadership of the facility. Despite pro forma compliance with administrative directives or external recommendations to create internal quality assurance processes, there is a self-sealing quality to those processes.

Staff who should be involved in the Mortality Review process are excluded. Its deliberations and activities are known to a select few and its impact on improving care of the living through studies of the care of the deceased is negligible.

The Special Review Committee, which does not interact with the Mortality Review Committee even when both are studying the same case, does not see all incident reports and therefore cannot spot patterns or trends and has no mechanism to assure follow up on any of its recommendations.

The Medical Adivisory Board, created as an independent overseer and advisor on medical care, has all of its input and output controlled by the person in charge of medical care--the former Director of Craig Developmental Center and present Deputy Director of Health Services at CDC. Thus, they see what the Deputy Director wants them to see and the Deputy Director acts on those of their recommendations that she chooses.

Reports of external reviews of facility operations are not shared with the staff and staff feel forced to go outside normal channels to get attention to their grievances.

Not surprisingly, under these circumstances little has changed.

Such efforts as have been made toward compliance with recommendations have been made under pressure, half-heartedly and poorly executed, guaranteeing their failure. When changes have occurred, as with the shift to the primary physician concept, they have been preceeded with insufficient discussion and consultation with the physicians involved, generating resistance rather than support. The method by which such changes have been accomplished has not enhanced whatever chances of success they might have had.

The victims of this dedication to the status quo, no matter how outdated it is, are the residents of Craig Developmental Center who have suffered from indifferent and substandard medical care. This foot-dragging can continue no longer. Failure to take the actions recommended by the Commission in this and previous reports will unquestionably result in further harm to the residents of Craig Developmental Center.

Therefore the Commission recommends that:

1. THE DEPUTY DIRECTOR FOR HEALTH SERVICES (DDHS) BE REMOVED.

During her tenure as former Director, the DDHS was in the position of exercising her authority and leadership toward the implementation of Commission recommendations and the improvement of medical services. She failed in her administrative capacity to meet this challenge and it is clear that the amelioration of problems besetting Craig and the continued health and well-being of its clientele require effective medical leadership.

(In response to this recommendation, the Commissioner of the State Office of Mental Retardation and Developmental Disabilities indicates agreement and reports the Deputy Director for Health Services will retire from the position.)

2. THE UTILIZATION OF THE PETERSON UNIT FOR ACUTE CARE SERVICES MUST CEASE IMMEDIATELY.

While this has been recommended in previous Commission reports, the follow-up review at Craig indicates that the Peterson Unit is still used as an acute care service. The lack of clearly stated admission and discharge criteria for this unit and the fact that it has no medical director, and physicians--who are unclear of its role--admit clients to the Unit, have contributed to the unit's inappropriate utilization for acute care. To facilitate the transition to an infirmary level of care, clearly-written admission and discharge criteria should be developed in consultation with the medical staff and disseminated to staff. As a symbol of the transition, consideration should be given to changing the name of the Peterson Unit.

(In response to the Commission recommendation, the OMRDD concurs that the Peterson Unit should be closed and reconstituted as an infirmary.)

3. ADDITIONALLY, THE PRIMARY PHYSICIAN MODEL OF CARE MUST BE ABANDONED AND A PHYSICIAN RECRUITED TO OVERSEE THE OPERATIONS OF THE PETERSON UNIT.

The ineffectiveness of the primary physician model of care was evidenced in the inappropriateness of referrals to the Peterson Unit, the untimeliness of referrals to community hospitals, and the lack of consistent follow-up by physicians when clients were returned from community hospitals. The physician recruited to serve in charge of the Peterson Unit should, therefore, oversee admissions and act as liaison with community hospitals to ensure appropriate referrals and aftercare.

(In response to this recommendation, the OMRDD agrees that the primary physician model should be abandoned and suggests utilization of nurse practitioners be examined and a new model for physician care developed.)

4. CONSIDERATION SHOULD BE GIVEN TO BEGINNING AN AFFILIATION WITH A LOCAL MEDICAL CONSULTANT GROUP FOR THE PURPOSE OF UPGRADING MEDICAL SERVICES PROVIDED.

Rochester Psychiatric Center has recently established such a relationship with Genesee Health Service Internal Medicine Group. Preliminary reports indicate that the benefits of the Rochester Psychiatric Center liaison are many: ongoing training is provided Rochester Psychiatric Center staff; Genesee provides consultants for Rochester Psychiatric Center's medical clinics, and a half-time internist for the Rochester Psychiatric Center Medical/Surgical Unit.

(In response to the Commission recommendation, the OMRDD indicates agreement that contracts with an outside medical consultant group should be pursued by Craig Developmental Center and that contacts with local hospitals, such as Rochester's Strong Memorial, should be broadened.)

5. ORGANIZATIONAL CHANGES MUST BE MADE REGARDING SUPERVISION OF PHYSICIANS AND PHYSICIANS ASSISTANTS AND THEIR INTEGRATION INTO THE OVERALL TREATMENT TEAM.

The importance of this integration must be reinforced through sound medical leadership. In addition, physicians must begin to take a more active role in interdisciplinary treatment team meetings.

(In response to this recommendation, the OMRDD concurs that changes must be made in the Health Services organization, and indicates responsibility for medical and non-medical services will be integrated under the new Deputy Director for Treatment Services as part of recent administrative changes at Craig, which include replacement of Craig's Director and Deputy Director for Treatment Services. The role of physician assistants will also be examined.)

6. BOTH THE MEDICAL ADVISORY BOARD AND MORTALITY REVIEW COMMITTEE MUST BE REVAMPED AND THEIR ROLES, AUTHORITY, AND MISSIONS CLARIFIED TO ENSURE VIABLE EXTERNAL AND INTERNAL MONITORING MECHANISMS.

The MAB needs staff support to function effectively. Staff must have access to all information pertaining to medical care. We offer the services of our staff.

(In response to the Commission recommendation, the OMRDD reports that revamping and clarification of <u>all</u> monitoring mechanisms at Craig will be addressed by the new management team.)

7. THE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES MUST TAKE A MORE ACTIVE ROLE TO ENSURE THE IMPLEMENTATION OF ITS OWN "CRAIG TECHNICAL ASSISTANCE PROJECT" AND THIS COMMISSION'S REPORT.

Progress reports on the status of the implementation of the recommendations should be provided to the Commission.

(In response to this recommendation, the OMRDD states that top level administrative staff have been replaced and the new administration directed to take immediate steps to correct deficiencies at the facility, with particular emphasis on medical care. A draft plan with target dates to accomplish the corrective action reportedly has been developed. OMRDD will provide the Commission with quarterly reports, the first of which is to be submitted on September 1, 1982.)

8. A QUALITY ASSURANCE MECHANISM AT CRAIG MUST BE ACTIVATED TO ENSURE A TIMELY IDENTIFICATION AND RESOLUTION OF INTERNAL PROBLEMS.

The current narrow focus of Craig's standing committees--the Special Review Committee and Mortality Review Committee--and the lack of communication between them thwart any meaningful exploration, identification and correction of problems presented in cases subject to the committees' reviews.

(In response to the Commission recommendation, the OMRDD indicates that Craig's new director and administrative staff have made procedural changes to insure that the Special Review Committee reviews all deaths and includes appropriate input from the Mortality Review Committee on the medical aspects of the deaths. The Director will also develop and implement Mortality Review Committee organizational and procedural changes to assure needed input from the Special Review Committee and consideration of non-medical issues in the Mortality Committee reviews.)

9. ONGOING IN-SERVICE TRAINING DIRECTED AT DEVELOPING TREATMENT PLANS TO MEET MEDICAL AND HEALTH CARE NEEDS AS WELL AS TRAINING TO TEACH ALL STAFF AT CRAIG THE TECHNIQUES OF WORKING AS A MULTIDISCIPLINARY TEAM MUST BE DEVELOPED AND MADE AVAILABLE.

(In response to this recommendation, the OMRDD reports that inservice training on treatment planning and the team process will be addressed as part of the "systems revision" at Craig Devleopmental Center.)

10. THE SPECIAL REVIEW COMMITTEE MUST BE REORGANIZED IN ORDER TO ALLOW ITS CHAIRMAN COMPLETE AND UNSCREENED ACCESS TO ALL INCIDENT REPORTS.

Additionally, the purpose of this Committee, the OMRDD policy for incident review, and the Committee's relationship to other Center committees must be identified and communicated clearly to all staff.

(In response to the Commission recommendation, the OMRDD states that the new Director and his staff are revising procedures to ensure that the Special Review Committee receives and reviews all reported incidents. In addition, all Craig staff will be made aware of the OMRDD's incident reporting policy and procedures and the role of the Special Review Committee and receiving training on their own incident reporting responsibilities.)

11. FINALLY, THE REPORTS OF THIS COMMISSION'S INVESTIGATORY AND REVIEW ACTIVITIES SHOULD BE DISSEMINATED TO ALL INTERESTED PARTIES AT CRAIG, PARTICULARLY THOSE WHOSE CONDUCT OR SERVICE WAS SUBJECT TO REVIEW.

Administrative changes resulting from recommendations must be communicated and discussed with all facility personnel.

(OMRDD concurred with this Commission recommendation.)