A Followup of

IMPLEMENTATION OF COMMISSION RECOMMENDATIONS TO IMPROVE PATIENT CARE

South Beach Psychiatric Center

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

August 1984

Clarence J. Sundram
Chairman

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Commissioners

PREFACE

The Legislature of the State of New York has conferred broad powers upon this Commission to investigate conditions affecting the quality of care in facilities and programs serving people with mental disabilities. Frequently, such investigations lead to recommendations by the Commission for changes in policy or practice to improve the quality of care. As the Commission has no formal enforcement powers, it depends to a considerable extent upon the commitment of mental hygiene officials in effecting the changes thought to be necessary or desirable.

As a matter of policy, from time to time, the Commission revisits facilities and programs where deficiencies have been previously identified to determine whether agreed-upon remedial measures have been implemented and, if so, whether they have had the desired positive effect.

This review of selected aspects of the operations of South Beach Psychiatric Center is in keeping with such a Commission policy. A draft of this report has been reviewed by the Office of Mental Health and South Beach Psychiatric Center. Their responses to new recommendations have been appended to the report.

The findings, conclusions and recommendations of this report represent the unanimous opinion of the Commission. We

are pleased to note that our follow-up study indicates that substantial strides have been taken by South Beach Psychiatric Center to effectuate changes that have resulted in significant improvements in vital areas of patient care.

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EXECUTIVE SUMMARY

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 and its Mental Hygiene Medical Review Board* have issued four formal reports** citing serious deficiencies in the care and treatment of deceased patients of South Beach Psychiatric Center (SBPC). The deficiencies cited by the Commission pertained to medication administration practices, the availability and working order of emergency medical equipment, treatment and discharge practices, and the utilization of restraint and seclusion.

In each report the Commission offered recommendations addressing the deficiencies noted, recommendations which SBPC and the Office of Mental Health (OMH) agreed to implement.

In March 1984 the Commission conducted a follow-up review at South Beach Psychiatric Center to ascertain the

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**In the Matter of Alphone Rio, A Patient at South Beach Psychiatric Center, March 1981; In the Matter of Janice Sherman, A Patient at South Beach Psychiatric Center, February 1982; In the Matter of Alex Zolla, A Patient at South Beach Psychiatric Center, May 1982; and In the Matter of Simon Paz, A Patient at South Beach Psychiatric Center, October 1983. All patient names are pseudonyms.

status of implementation of its recommendations, and to assess the extent to which the steps taken to correct deficiencies have resulted in improvements in care and treatment. In this endeavor, Commission staff interviewed senior staff of the Office of Mental Health, and administrative and treatment staff at SBPC. Additionally, Commission staff reviewed selected aspects of the care and treatment of 35 South Beach patients.

FINDINGS

Generally, the follow-up review indicated that South Beach had made significant progress in implementing the Commission's recommendations and improving the quality of care afforded its patients.

Medication Administration Practices (Report pp. 3-7)

Previous Commission investigations revealed that SBPC's medication administration practices deviated from accepted clinical standards expressed in the Office of Mental Health's Psychotherapeutic Drug Manual. Specifically, the Commission found that medications had been ordered and frequently changed with no documented rationale and that senior psychiatrists were not consulted when medications exceeded recommended dosages. As such, the Commission recommended that South Beach adhere to the guidelines of the OMH's drug manual.

In the follow-up review Commission staff scanned the medication regimens of approximately 130 patients and found 12 who, during the previous two months, had changes in their medications or received medications in dosages exceeding recommended levels. These 12 cases were reviewed in detail. In each case it was found that SBPC had followed the OMH's standards: rationales were present in the records for all changes in medications and consultations with senior staff were secured and justifications documented in those cases where dosages exceeded recommended levels.

Emergency Medical Equipment (Report pp. 7-9)

The availability, accessibility and working order of emergency medical equipment as well as staff preparedness for its use were areas of inquiry during the follow-up review. Previously, the Commission had found that an ill-equipped "crash cart" and malfunctioning suction machinery delayed the administration of emergency medical care to a patient who subsequently died. In reporting on this death, the Commission recommended that SBPC take steps to ensure the operating order of its emergency medical equipment and staff preparedness for its use, and that the Office of Mental Health develop statewide policies on the matter.

During the follow-up review, it was found that SBPC had fully implemented the Commission's recommendation: an inventory of emergency medical equipment to be present on units had been developed; schedules for equipment inspections were established and staff were trained in the equipment's

use. In visiting SBPC's wards, Commission staff found that units were fully equipped with the items listed on the inventory, the items were inspected as scheduled, and SBPC staff could demonstrate the proper use of the equipment.

The follow-up review, however, indicated that the OMH had not, as yet, circulated statewide policies on the issue of emergency medical equipment.

Treatment and Discharge Planning and Follow Up (pp. 9-23)

Two of the Commission's previous investigations revealed glaring deficiencies in the areas of treatment and discharge planning and follow up. These included untimely assessments and the delayed development of treatment plans; lack of consultations with senior staff on difficult-to-treat patients; and precipitous discharges with no follow up. In its reports on these cases the Commission offered recommendations to improve the timeliness of treatment planning and the availability of senior staff for consultations, and to foster team participation in treatment and discharge planning and follow up upon discharge.

During the follow-up review, Commission staff reviewed the records of nine patients: six were patients at the time and three had been discharged several weeks prior to the review. On the basis of the review and discussions with SBPC staff, it was clear that SBPC had taken steps to improve the treatment, discharge and follow-up processes. While certain problems were noted in the timeliness of the completion of

treatment plans for patients on the BARS Unit (SBPC's Admission Unit), generally assessments and plans were completed in a timely and comprehensive manner, and Commission staff were impressed with the thoroughness and content of the treatment records and steps taken to transition patients to the community. Additionally, it was learned that senior consultants were available 24-hours-a-day, team meetings were held daily to discuss the progress of patients, and a system for follow up after discharge had been implemented. However, it was learned that not all decisions reached at team meetings were documented in patients' records and that the system for follow up on patients' upon discharge was limited to only those patients discharged to SBPC's outpatient clinics.

Restraint and Seclusion Practices (Report pp. 23-28)

The follow-up review also revealed improvements in restraint and seclusion practices at SBPC. Previous investigations had revealed flagrant violations of Mental Hygiene Law and OMH regulations and policies governing the utilization of these interventions: patients were restrained or secluded for extended periods of time; physicians did not examine the patients; and, rationales for the intervention were lacking. However, the Commission's March 1984 review of 14 incidents of restraint and seclusion indicated that the majority were carried out in accord with applicable laws, regulations and policies, and only minor deficiencies were

were noted in a few cases. However, it was noted that several seclusion rooms were in need of repair and maintenance.

CONCLUSIONS AND RECOMMENDATIONS

On the basis of the Commission's review, it is clear that South Beach has made great strides in correcting previously cited deficiencies and the preponderance of positive findings revealed during the review speaks well of South Beach's efforts to upgrade the quality of care for patients it serves. The Commission applauds the many changes instituted at the Center.

However, the Commission's review also indicated areas in need of further action on the part of South Beach Psychiatric Center and the Office of Mental Health to ensure a uniformly high level of care. Toward that end the Commission recommends that:

1. South Beach review BARS Unit staff's compliance with the Office of Mental Health's record keeping policies and procedures with regard to initial assessments and treatment planning, and discharge documentation.

2. South Beach should consider documenting decisions made in the daily treatment team meetings when such decisions reflect changes in treatment approaches/plans or indicate resolution of difficulties related to treatment and discharge planning.

3. South Beach should develop a procedure for following up on patients who are discharged and whose plans for aftercare do not include attendance at a South Beach Psychiatric Center outpatient clinic. While it is recognized that SBPC has established a liaison system with its outpatient clinics to ensure a smooth transition from inpatient to outpatient care, it was evident that patients are at times discharged with plans to attend non-SBPC outpatient clinics. In such cases, SBPC should follow up to ensure that the plans are in fact implemented.

4. Given the idiosyncratic problems noted during the review of 14 instances of restraint and seclusion, South Beach Psychiatric Center should initiate a process for conducting ongoing audits of restraint and seclusion practices for the purposes of providing feedback to Units and counseling and training for staff whose performance in this area is less-than-adequate. Additionally, South Beach should reiterate to staff the standards for and importance of monitoring vital signs of patients in restraint or seclusion.

5. South Beach should take steps to correct conditions in the seclusion rooms on the Sheepshead Bay and Structured Treatment Units and to install electronic temperature gauges in the seclusion rooms on the BARS Unit.

6. The Office of Mental Health should expedite the promulgation of statewide policies regarding the availability and inspection of emergency medical equipment and staff preparedness on its use.

In keeping with the Commission's policy, a copy of this report was shared with the Office of Mental Health and South Beach Psychiatric Center in draft form for review and comment. As indicated in the Office of Mental Health's response (Appendix 1), the Office of Mental Health and South Beach Psychiatric Center concur with the Commission's findings and have agreed to implement the Commission's recommendations.

CHAPTER I

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 and its Mental Hygiene Medical Review Board* have had occasion to issue four formal reports** describing serious deficiencies in the care and treatment of deceased patients of South Beach Psychiatric Center (SBPC).

The deficiencies cited in these reports pertained to medication administration practices, the availability and working order of emergency medical equipment, treatment and discharge practices, and the utilization of restraint and seclusion. In each report, the Commission offered recommendations addressing the deficiencies noted. South Beach Psychiatric Center and the Office of Mental Health (OMH) agreed to implement these recommendations.

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As the Commission has no statutory enforcement powers, if recommendations made by the Commission are not implemented or if the institution of corrective action does not produce the desired change, the Commission's primary recourse is to continue to report such findings to the program operators and regulators, to the Governor and Legislature, and to the public. Thus, the Commission periodically conducts follow-up surveys to ascertain the status of implementation of its recommendations and to assess the extent to which steps taken to correct deficiencies have resulted in improvements in the care and treatment of mentally disabled persons.

In March 1984 the Commission conducted such a follow-up review at South Beach Psychiatric Center. In this endeavor, Commission staff interviewed senior staff of the OMH and administrative and treatment staff at SBPC. Commission staff also reviewed selected aspects of the care and treatment of 35 individuals who were patients at SBPC in February and March 1984.

This report details the findings, conclusions, and recommendations stemming from the Commission's follow-up review. Chapter II presents a brief overview of the deficiencies found and recommendations issued in the Commission's previous reports, and the methodology and findings of the follow-up review. The Commission's conclusions and recommendations are presented in Chapter III.

CHAPTER II

Findings

The Commission's follow-up survey entailed a focused review of South Beach Psychiatric Center's current practices with regard to the four major areas of deficient care identified in the investigation of the four deaths. In the conduct of this review, Commission staff found that SBPC has, in most instances, instituted agreed-upon corrective actions in accord with Commission recommendations. With few exceptions, the 35 patients whose records were reviewed for selective aspects of treatment, appeared to have received good care and there was little evidence that previously cited inadequacies still exist.

Medication Administration Practices

In the cases of Alphonse Rio and Janice Sherman, the Commission noted several deficiencies in medication practices. Numerous medications had been ordered and medication changes instituted without any explanation in the record, in an attempt to manage Ms. Sherman's agitated behavior. No rationale was given for the ordering of medication for Mr. Rio in dosages exceeding recommendations in the Physician's Desk Reference (PDR) and the OMH Psychotherapeutic Drug Manual. In addition, other inadequacies involving medication practices, such as confusing medication start-dates

and the lack of consultation with senior physicians when prescribing medication exceeding recommended dosages, were found in the case of Mr. Rio. Thus, the Commission recommended that SBPC adhere to the standards of the OMH Psychotherapeutic Drug Manual including:

- providing progress notes on changes or increases in medication; and
- documenting rationale and securing consultation with senior psychiatrists when exceeding recommended dosages.

The Commission also recommended that when a physician orders a medication and simultaneously orders a delay in its administration, exact times and dates for its initiation should be noted.

South Beach agreed with the Commission's recommendations. The Psychiatric Center's response also indicated that the Rockland Drug Ordering and Monitoring System had been instituted at the Center and that under this system prescriptions exceeding recommended dosages would be flagged as an "exception" and would require special justification by the prescribing physician's clinical supervisor. The SBPC's response also indicated that staff psychiatrists would be instructed to ensure adherence to proper practice with regard to delays in administration of prescribed medications.

The Commission planned to monitor the implementation of these recommendations by selecting the records of 15 patients

from three units,* (BARS, SBPC's Admission Unit; Intensive Care Unit; and, Heights Hill) whose medication or dosages had been changed, or whose prescribed medications exceeded recommended dosage in the month of February 1984.

At the time of the survey in March 1984, however, Commission staff had to extend the time frame under review to two months and include a fourth unit, Fort Hamilton, in order to obtain an appropriate, though smaller-than-planned, sample size (12 patient cases). That only 12 cases could be found on four units serving more than 130 patients over a two-month period is an important finding in itself, as prior Commission reviews had often revealed that medication changes, and orders for medication exceeding recommended dosages were not uncommon at this facility.

In all 12 cases reviewed, the physician's rationale for change in the type and dosage of medication was documented and such documentation was consistent with other record entries. This is noteworthy in that all but one patient had had multiple changes in medications and each time the physician's rationale was recorded. In total:

- two patients had four medication changes;
- five patients had three medication changes;
- four patients had two medication changes; and
- one patient had one medication change.

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*Ms. Sherman was a patient on the BARS Unit and Mr. Rio was a patient on the Intensive Care Unit. The third unit was selected at random.

Commission staff also noted that there were no orders to delay the initiation of prescribed medications in any of these instances of medication changes.

Two of the 12 patients' medication dosages exceeded the OMH Psychotherapuetic Drug Manual guidelines. Both individuals were long-term patients residing on the Heights Hill Unit. In both cases, consultations were held with senior psychiatrists and were documented, and approval to prescribe higher-than-recommended dosages had been obtained from the Medication Exceptions Committee. Although it is apparent that South Beach had taken appropriate steps and had adhered to OMH policies and procedures, the Commission questioned the length of time these patients had been receiving medication dosages exceeding the Psychotherapeutic Drug Manual's recommendations without additional or periodic reviews by senior psychiatrists. In one instance, the consultation had taken place nearly a year prior to the Commission's review. In the second case, four months had passed since the patient's medication regimen had been reviewed by a senior psychiatrist.

The Commission's concerns and questions about the frequency of consultations with senior psychiatrists regarding the prescription of higher-than-recommended medication dosages were raised with the facility's Director of Clinical Services who indicated that South Beach is addressing this issue and is in the process of developing its own policies and procedures in this regard.

According to the Director of Clinical Services, the procedures will require that:

- o unit psychiatrists consult with the Director of Clinical Services or the Chief Medical Officer before initiating the medication regimen and at least every three months thereafter; and
- o documentation of the consultations be entered in the patient's record.

The addition of such policies and the generally positive findings related to the medication practices reviewed indicate that South Beach has implemented corrective measures consistent with Commission recommendations.

Emergency Medical Equipment

Commission staff also found that South Beach has taken steps to ensure properly operating emergency medical equipment and staff preparedness for the use of such equipment.

In the review of the circumstances surrounding the death of Alex Zolla, the Commission found that SBPC was ill prepared to meet a medical emergency. On the day of his death, when Mr. Zolla was found lying in restraint, cyanotic, with no pulse and with dilated pupils, an emergency code was called and resuscitation equipment ordered. However, the suction machine on Mr. Zolla's ward was inoperable and the crash cart was on a different floor. When the crash cart was brought to Mr. Zolla's floor, it had no tourniquet. Consequently, a physician removed tubing from a second suction machine, which was brought to Mr. Zolla's ward by security

officers, in order to fashion a tourniquet to start an intravenous. Subsequently, resuscitation efforts were unsuccessful and Mr. Zolla was pronounced dead.

In its report on the Zolla case, the Commission recommended that South Beach periodically review the availability, accessibility, and operating order of its emergency medical equipment and that the OMH should develop a protocol establishing the frequency with which such reviews should be conducted.

South Beach agreed with this recommendation and indicated that a system of periodic reviews of emergency medical equipment and staff preparedness was presently in existence at the facility.

During its March 1984 review, Commission staff secured a list of all emergency medical equipment required to be present on wards and visited three units (Heights Hill, BARS and Structured Treatment) to conduct an inventory of the equipment actually present. Unit staff were also asked to demonstrate its use and operating condition.

The Commission's follow up in this area revealed that South Beach has a system in place to ensure the availability, accessibility and working order of emergency medical equipment. A list of all emergency medical equipment was present on the three units, as were emergency carts. All of the listed equipment was present in each unit, and had recently (within the past three months) been inspected by an outside

contractor. Labels affixed to the equipment indicated the dates of the inspection and when the next review would be done. Certain pieces of equipment, such as oxygen tanks and suction apparatus, are checked daily on each shift and such checks were documented.

As emergency medical equipment is most often used by registered nurses, Commission staff asked a nurse on each ward to demonstrate and explain the use of the equipment. All of the nurses were able to do so, and all told Commission staff that they had participated in an emergency equipment review within the last year and were certified.

According to South Beach Psychiatric Center's Director of Nursing, in addition to annual emergency medical recertification reviews conducted on the anniversary date of each nurse at the facility, monthly informal drills are also held with nurses on each ward.

At the time of the Commission's follow-up review, the Office of Mental Health had not as yet established a statewide protocol for the review of emergency medical equipment in psychiatric centers. However, according to a representative of the OMH's Bureau of Health Care Management, such a protocol -- as well as staff training protocol -- are "in progress" and are expected to be disseminated to all psychiatric centers by late fall 1984.

Treatment and Discharge Planning and Follow Up

In investigating the deaths of Janice Sherman and Simon Paz, the Commission found glaring deficiencies in treatment and discharge planning. Ms. Sherman, who was admitted from Kings County Hospital to the BARS Unit on a holiday weekend, did not receive a physical examination until four days after her admission, and laboratory work on this patient was not completed until five days after admission. This patient had been highly agitated, and in an attempt to manage her behavior she was transferred from unit to unit. Ms. Sherman was transferred through four groups of treatment teams in six days without the benefit of intervention by senior psychiatrists or a conference among the many physicians who attended the patient during the six-day period. Comprehensive treatment planning was lacking and therapeutic assessments by physicians were not documented. Similarly, Mr. Paz was a difficult-to-treat patient and had an extensive history of alcohol and illicit drug abuse. Several of his many admissions to inpatient care over a five-year period had been precipitated by threats of suicide by jumping from bridges or roof tops.

Mr. Paz was admitted to South Beach Psychiatric Center three times in seven weeks--the second admission occurred 20 days after he had last been on the BARS Unit. For his last two discharges, the Commission's investigation revealed that South Beach clinicians had not complied with the OMH policies

which govern the discharge of patients. There was no follow up on his discharge after his first admission, despite notification from the outpatient agency that he had failed to make contact for aftercare services. Similarly, follow up was also lacking after discharge from his second admission. His third discharge was ordered by a psychiatrist covering the unit for another psychiatrist. The decision to discharge the patient was made unilaterally by the covering psychiatrist who believed Mr. Paz's agitated and assaultive behavior was manipulative. After an episode of throwing chairs on the unit, this physician wrote an order to seclude the patient, then discharge. No discharge planning or arrangements for services was done; Mr. Paz was released as per the psychiatrist's order and within hours committed suicide. In these two cases, the Commission made a number of recommendations regarding assessments, treatment and discharge planning and follow up.

A. Assessment and Treatment Practices

In the case of Janice Sherman, the Commission recommended that South Beach initiate policies to ensure that newly admitted patients receive a mental status examination and that evaluations--including STAT (immediate) work-ups and treatment planning--are not hindered by the fact that patients are admitted on weekends or holidays. Further, the Commission stated that the facility should institute policies regarding newly

admitted patients who do not respond to treatment and whose condition worsens during the first 24-48 hours after admission. The Commission recommended that in such cases senior psychiatrists should be apprised of the patient's condition, and that the physicians should confer with one another to evaluate the current treatment regimen with an emphasis on the development of an individualized treatment plan geared to the specific needs of the patient.

In response, South Beach indicated that the Unit Chief on the BARS Unit is available ("on call") 24-hours-a-day to consult with physicians on difficult admissions and that the staff on this unit have begun holding weekly case conferences.

To determine the extent to which South Beach Psychiatric Center's current initial assessments and treatment planning practices are in keeping with Commission recommendations, during the Commission's follow-up survey the records of nine patients on the BARS Unit were reviewed to determine:

- the adequacy and timeliness of assessments (including mental status exams) and initial and comprehensive treatment plans;
- whether STAT orders are carried out in a timely fashion;
- whether the BARS Unit Chief is available to be on call 24-hours-a-day;

- whether consultations with senior psychiatrists are held as needed and whether such consultations are documented; and
- whether weekly case conferences are held.

Patient records were selected to include three individuals admitted to the BARS Unit on a weekend, three patients identified by BARS Unit staff as being "difficult-to-treat," and three patients discharged in February 1984.

On the whole, Commission findings in this area were positive. All nine patients received adequate mental status exams upon admission, including the three patients who were weekend admissions.

Consistent with Office of Mental Health policies and procedures, specific initial assessments were conducted within the required time frames for all patients:

- screening and admission notes were completed on each patient within the mandated 24 hours;
- patient care assessments were completed within 48 hours; and
- interim treatment plans were developed within the required 72-hour period.

Commission staff found that the assessments in general were comprehensive and although some of the required information was missing from certain forms, this data could be found in other parts of the record. For example, in certain cases information concerning the patient's family situation or number of previous

hospitalizations was not contained in screening and admission notes. However, this information was found in other assessments or in the progress notes.

Other required assessments, including physical examinations and comprehensive treatment plans, were completed on most patients in accord with OMH policies and procedures. However, the review indicated the need for concentrated effort on SBPC's part to ensure that all patients receive required assessments and the benefit of treatment plans within the mandated time frames.

Six of the nine patients reviewed had physical examinations within 24 hours of admission as required. Three patients did not receive physical exams within the specified time frame. One of these, R.C., a patient chosen for review because he was designated by BARS Unit staff as being a "difficult" patient, received a physical exam within 48 hours. The second patient was examined by a physician who did not date the physical exam form. And, the third patient was examined three days post admission; however, notes in the record indicated that the patient had refused the examination on admission.

In reviewing the nine records, Commission staff found that a STAT test was ordered for only one patient and this test was done on the same day it was ordered.

With regard to treatment planning, eight of the nine patients' records contained comprehensive treatment plans. No comprehensive treatment plan had been developed for "difficult" patient R.C. on the BARS I Unit. Of the eight comprehensive treatment plans present, six were completed within the first 11 days of admission as required by OMH policies, and the remaining two plans were three and five days late, respectively.

The treatment plans reviewed appeared relevant to the patient's needs as identified on the initial assessments. Goals delineated on the plan often did not specify the individual staff member responsible for implementation. However, progress notes entered in the record were more specific and spelled out quite clearly what was being done and by whom. In fact, Commission reviewers were impressed with both the content and frequency of progress notes by clinicians involved in treating the patients. Specifically, there were almost daily therapist's notes, and weekly or more frequent notes from the treating psychiatrists. These notes were focused, relevant, and indicated that treatment was being geared toward preparing the patient for discharge.

Another significant finding was that although none of the nine patients' conditions worsened within the first 24-48 hours of admission, consultations with senior psychiatrists were held for three of the nine

patients reviewed when difficulties arose during their stay on the unit. For example, patient P.P. was seen for several consultations by a senior psychiatrist because his psychiatric symptoms were not abating and he was acting out sexually on the ward. The senior psychiatrist's involvement with this patient continued until relief of symptoms was accomplished. Consultation notes were entered in the record in each instance. Commission reviewers also found through interviews with BARS Unit Chief and ward staff, that the Unit Chief is on call 24-hours-a-day and is available for consultations when difficult patients are admitted.

While South Beach Psychiatric Center in its response to Commission recommendations stated that weekly case conferences are held on the BARS Unit, on the basis of interviews with treatment staff the Commission found that such conferences actually occur on a more frequent basis. Patient rounds and treatment team meetings are held daily, are attended by the Unit Chief and all patients are discussed. "Difficult" patients and patients who present discharge disposition problems are singled out for special attention in these meetings. In addition, all newly-admitted patients are interviewed by the team on the day of their admission. These daily meetings appear to be the forum in which treatment and discharge planning decisions are made.

The Commission was pleased to find this system of ongoing decision making and communication among members of the treatment team. It was, however, difficult for Commission reviewers to ascertain the specific impact of such meetings on patient care since team discussion/ decisions relative to individual patients are not documented.

Another issue of documentation that arose in the course of the Commission's follow up of admission assessments and treatment planning practices involved the matter of reviewing patient records from previous hospitalizations. While treatment plans for eight of nine patients reviewed listed "obtain and review prior records" as a goal, Commission staff found no evidence that such records were, in fact, obtained or reviewed. It was unclear whether BARS Unit staff had implemented this goal and had not documented the results of their review, or whether the records were never secured.

B. Discharge and Follow-up Practices

As indicated previously, the Commission cited egregious deficiencies regarding discharge practices in the case of Simon Paz. Due to this patient's assumed manipulative behavior and assaultiveness, he was, on the order of one physician, secluded until he was precipitously discharged. Mr. Paz left South Beach without any preparation, and no one on staff knew whether he had

adequate financial and residential supports or whether Mr. Paz was aware of proposed plans to refer him for substance abuse treatment.

In view of these serious inadequacies, the Commission made several recommendations, among which were that South Beach Psychiatric Center should:

- ensure that patients are not discharged unilaterally and precipitously, and that patients are not discharged on the same day that they have been restrained or secluded;
- foster the team concept of treatment and encourage consultations and second opinions;
- define what is expected of staff if they disagree with a physician's decision on discharge or other critical treatment issues; and
- review its policies on discharge planning and the handling of multiple admissions.

In response to these recommendations, South Beach informed the Commission that:

- a policy memorandum had been issued prohibiting the discharge of a patient on the same day that the individual has been in restraint or seclusion except when written approval has been obtained from the Director of Clinical Services or designee;
- as of October 1983, facility reviews of discharge practices will be conducted on a quarterly basis by the Center's Discharge Planning Committee; and
- social work supervisors will meet monthly with the Center's Chief Social Worker to review discharge planning and to receive training in this area.

To monitor the implementation of these proposed corrective actions, Commission staff reviewed the records of three BARS Unit patients who had been

discharged three or more weeks prior to this survey. The review focused on (1) the adequacy of the plan for discharge; (2) whether individuals who knew the patients participated in the preparation of the plan, including relatives and the patient; and, (3) whether follow-up steps were taken to ensure the implementation of the plan. Commission staff also interviewed the Unit Chief, the Chief Social Worker and other treatment staff.

As discharge planning starts on the day the patient is admitted to the inpatient unit, the three individuals whose records were reviewed for this aspect of the survey were also included in the review of admission and treatment planning practices. Commission staff found that initial assessments and treatment plans, as well as ongoing interventions, appeared to be geared toward preparing the patient for discharge. Staff efforts to find appropriate housing and to deal with family problems as well as other problems that precipitated admission to the facility seemed to be addressed throughout the course of treatment.

Discharge plans for two of the three selected patients were generally very good. References were made in progress notes to steps being taken by staff to arrange for appropriate post-discharge care. Outside parties were also involved in such efforts. For example, the social worker from a home for adults where

one patient, L.R., was to be discharged, met with the patient, attended team meetings on the BARS Unit, and was frequently contacted by L.R.'s primary therapist to work out specific plans.

In the case of the second patient, J.L., the SBPC's primary therapist maintained ongoing communication with the patient's father and arranged a series of gradually lengthening home visits prior to his discharge to promote J.L.'s adjustment to his home environment. Since family problems were a factor in this patient's recurring hospitalizations, the primary therapist also worked with the father in an effort to engage him in ongoing family therapy with the patient at the outpatient clinic.

Commission findings relative to the third patient's discharge were less favorable. Patient G.D. had been admitted to South Beach Psychiatric Center's BARS I Unit following a suicide attempt precipitated by problems with her husband. Staff contacted G.D.'s husband and learned that he did not want her to return to their home upon discharge. G.D.'s discharge plan indicated that (1) the patient, following her eight-day stay on BARS I Unit, was sent by bus to her daughter's home in upstate New York, and (2) that outpatient clinic and other arrangements would also be made by the daughter. Although the daughter had been contacted by SBPC via

telephone and informed of this plan, the record did not indicate whether SBPC ever contacted the daughter subsequent to G.D.'s discharge to determine that the plan was implemented successfully. Considering that the patient was hospitalized following a suicide attempt, that she had not seen her daughter in ten years, and that no definite outpatient care referrals had been made, the Commission questioned the adequacy of the discharge plan, especially in light of the lack of follow up on SBPC's part.

As indicated previously, the issue of lack of follow up after discharge was particularly problematic in the case of Simon Paz. During the Commission's follow-up survey, it was learned that responsibility for ensuring the implementation of discharge plans rests primarily with outpatient clinic staff who are responsible for contacting patients who have missed outpatient appointments. South Beach has established a liaison system in which outpatient staff from each of its clinics meet weekly with inpatient staff to discuss patients about to be discharged. This system ensures that linkages are made to SBPC's outpatient services before the patient is discharged. In fact, it was reported that many patients actually attend their outpatient clinic before they are discharged. While this system was developed to ensure the likelihood that

patients will participate in aftercare services, it does not ensure the follow up of patients who, like G.D., are discharged with plans to attend a non-SBPC outpatient clinic. Thus, it appears that SBPC should take additional steps to ensure that plans for aftercare are in fact implemented when such plans involve non-SBPC service providers.

One other deficiency encountered in reviewing this aspect of care involved documentation of discharge plans. The Office of Mental Health requires staff to complete certain "paperwork," such as the Individual Service Plans (ISPs) and discharge summary within specific time frames (15 days of discharge). Commission staff found that Individual Service Plans and discharge summaries had not been completed in a timely fashion for L.R. and J.L., both of whom were patients on the BARS II Unit. Although it was apparent that arrangements for outpatient care had been underway throughout these patients' hospitalizations, information usually detailed on ISPs and discharge summaries is essential for treatment planning by staff of outpatient clinics to which patients are referred.

Commission reviewers had noted at the time patients were selected for inclusion in this area of the review, that "discharge paperwork" had not been completed by BARS II staff for most of the patients discharged during

the month of February 1984. This lack of timeliness in completing necessary paperwork appeared to be endemic to BARS II. In contrast, all of the mandated documentation for patients discharged from BARS I during the same period had been completed in accord with OMH policies. Additional supervision of BARS II staff in complying with such policies appears to be indicated.

As is apparent from the descriptions of the discharge planning process for the three selected patients, none of these individuals was discharged precipitously either on the basis of a unilateral decision, or did there appear to be any discord relative to the decisions to discharge.

Commission reviewers asked the Unit Chief and clinical staff in individual interviews whether dissenting opinions about decisions to discharge were ever voiced. Both the Unit Chief and the treatment staff indicated that there is disagreement in very few instances, and that the dissenting viewpoint was usually expressed by the Unit Chief who then "vetoes" the decision and presents convincing arguments to support his decision. Based on these interviews, it appears that care is being taken to ensure that decisions to discharge patients are the result of a team discussion and that the Unit Chief is exercising his authority to prevent precipitous discharges.

Finally, Commission staff also found that South Beach has sent in motion its own reviews of discharge planning practices. The Chief Social Worker, who also chairs the Discharge Planning Committee, is conducting monthly meetings with all Senior Social Workers and/or a representative from each of the facility's units. During these meetings topics of concern and general problems are discussed.

The Discharge Planning Committee meets quarterly and audits 30 randomly selected Individual Service Plans. The results of such reviews are kept by the Chief Social Worker and she develops a list of deficiencies which is then circulated to all Team Leaders and Unit Chiefs. Staff cited for several deficiencies are singled out and counseled.

Restraint and Seclusion Practices

The Commission's prior investigations at South Beach Psychiatric Center revealed significant deficiencies in restraint and seclusion practices and numerous violations of Mental Hygiene Law concerning these practices.

In the Alphonse Rio case, Commission investigators noted a lack of adherence to New York State Mental Hygiene Law and OMH policies governing restraint and seclusion. This agitated patient was restrained or secluded for long periods of time. Mr. Rio was not routinely examined by a physician

prior to being restrained or secluded, physician rationales justifying the need for restraint and seclusion were lacking, and the patient's condition was not periodically monitored. Additionally, the lack of adequate climate control (heat and ventilation) created uncomfortable conditions in seclusion rooms exposed to direct sunlight.

Similarly, nearly all of these inadequacies were revealed in the investigation into Janice Sherman's death. Additionally, in the Sherman case the Commission found the ordering of restraint and seclusion on a PRN (as needed) basis which is prohibited by State law and policies.

Finally, in the case of Alex Zolla, the Commission noted laxity with regard to physicians documenting the rationale for ordering restraint or seclusion.

In view of such deficiencies, the Commission in each report recommended that South Beach Psychiatric Center take steps to ensure compliance with standards governing the use of restraint and seclusion. In the Alphonse Rio case the Commission additionally recommended that South Beach institute measures to ensure better climate control in seclusion areas.

The Office of Mental Health and South Beach Psychiatric Center agreed to conduct audits of staff compliance with OMH policies and Mental Hygiene Law and to reinforce staff awareness of these policies. South Beach also indicated that covers would be placed over windows to reduce direct

sunlight, and that electronic temperature gauges would be installed which would enable staff to monitor the temperature in seclusion areas.

Initial Commission follow-up plans to ascertain current compliance with standards on restraint and seclusion called for reviewing 18 incidents of restraint and seclusion on three different units (BARS, Heights Hill, and the Structured Treatment Unit) with the intent of observing the actual restraint or seclusion at the time of the review. Once again, however, the plan was amended because with the exception of the Structured Treatment Unit, Commission reviewers could find few instances of the use of restraint and seclusion. In fact, Commission staff did not observe any patients being restrained or secluded during the 12 staff days spent onsite during the course of the follow-up review. In order to find a large enough sample, Commission staff reviewed incidents of restraint and seclusion on five units (Ft. Hamilton and Sheepshead Bay Units were added) over a six-week period. A total of 14 instances of restraint and four incidents of seclusion were reviewed.

That South Beach is infrequently restraining or secluding patients is a noteworthy and significant finding. Significant also is the degree to which South Beach is adhering to restraint and seclusion regulations.

The use of restraint or seclusion appeared justified in 13 of the 14 cases reviewed. Only one case of seclusion

seemed questionable. Patient P.Z. (BARS II) was placed in seclusion after he showed staff that he had placed a shoelace around his neck to hang himself. The Commission questioned why he was placed in seclusion rather than on one-to-one observation on the ward.

Physicians' orders were present in all but one case--again patient P.Z. on the BARS II Unit--where physician order sheets for an eight-day period were missing from the record. In all 14 cases there was evidence that physicians had examined the patients in restraint or seclusion, and in 13 of the 14 cases, the physician recorded the results of his/her examination. In the one case (J.G., Sheepshead Bay Unit) where the physician did not record the findings of his examination, there was a lengthy nursing note which indicated that the patient had been examined by the physician.

Rationales for restraint and seclusion were documented in each instance. In addition, Commission staff saw evidence that all patients were released after two hours and that all patients were observed every 15 minutes in accord with OMH policies and procedures.

In general, substantial compliance with Mental Hygiene laws and OMH policies was noted. The only aspect of policy adherence that was subject to question by Commission reviewers involved the taking of vital signs. OMH regulations indicate that vital signs should be taken in accord with the physician's orders. Commission staff noted that

such orders varied from unit to unit and among physicians. Vital signs were not always taken as ordered (three instances on BARS II) and rationales for not following doctors' orders were not recorded.

At the time of the follow-up survey, Commission staff also inspected the seclusion rooms on the aforementioned units to determine whether promised corrections had been made, including reducing sunlight in these areas, installing electronic temperature gauges, and also eliminating sharp edges on radiator covers. Commission staff verified that South Beach had corrected all previously cited deficiencies with the exception of the BARS Unit where electronic temperature gauges have not yet been installed.

While most of the previously cited deficiencies relating to seclusion rooms have been addressed, different inadequacies surfaced during the course of this survey. Specifically, seclusion rooms on the Sheepshead Bay and Structured Treatment Units were found to be in poor condition and in need of immediate attention.

Deficiencies discovered in a seclusion room on the Sheepshead Bay Unit included:

- severe signs of water leakage on the ceilings and walls;
- plaster stripped from the walls by patients;
- a light fixture hanging from the ceiling which could be pulled out by patients; and,

- an opening on the side of a seclusion door where a lock mechanism had been removed. (SBPC staff told Commission reviewers that patients grab onto the opening when fighting to keep the door open, creating the potential for patient injury.)

On the Structured Treatment Unit seclusion rooms were in need of attention. One seclusion room, which was under repair at the time of the follow-up visits, smelled of urine. Walls and floorboards in each of the seclusion rooms were marked up and the heating/air conditioning units were dirty and papers had been stuffed under their protective covers.

CHAPTER III

Conclusions and Recommendations

Over the course of the past four years, Commission investigations into the circumstances surrounding the deaths of four patients at South Beach Psychiatric Center revealed serious inadequacies in the care and treatment offered by that facility. Specifically, the investigations revealed medication practices which deviated from accepted standards with no rationale or justification; inoperable and unaccessible emergency medical equipment; delays in the development and implementation of treatment plans to address the specific needs of individuals; precipitous discharges with no follow up; and numerous violations of Mental Hygiene Law and policies governing the utilization of restraint and seclusion. In reporting the findings of these investigations, the Commission issued recommendations to improve the quality of care and treatment at South Beach, recommendations which both South Beach Psychiatric Center and the Office of Mental Health agreed to implement.

On the basis of the Commission's review of the status of implementation of these recommendations, it is clear that South Beach Psychiatric Center has made great strides in correcting the previously cited deficiencies and in improving the quality of care afforded to the patients it serves. As recommended, the facility is adhering to OMH standards

governing medication administration practices, including requirements for consultations and documenting justification for medication regimens. The facility has also initiated a system to ensure the availability, accessibility and working order of emergency medical equipment and staff preparedness for its use. Additionally, steps have been taken to improve treatment and discharge planning and implementation processes. Specifically, the facility has fostered a team approach to these processes through frequent meetings, and the utilization of senior clinical staff consultation in patients who pose treatment or discharge problems. The follow-up survey also revealed substantial compliance with OMH guidelines concerning the conduct of initial assessments and the development of individualized initial and comprehensive treatment plans. Finally, the Commission's follow-up findings indicated substantial compliance with laws and policies governing the use of restraint and seclusion.

The preponderance of positive findings revealed during the Commission's follow-up survey, speaks well of South Beach's efforts to upgrade the quality of care afforded its patients. The Commission applauds the many changes instituted at the Center. However, the Commission's review also indicated areas in need of further action on the part of South Beach and the Office of Mental Health to ensure a uniformaly high level of care. Toward that end, the Commission recommends that:

1. South Beach review BARS Unit staff's compliance with the Office of Mental Health's record keeping policies and procedures with regard to initial assessments and treatment planning, and discharge documentation.

2. South Beach should consider documenting decisions made in the daily treatment team meetings when such decisions reflect changes in treatment approaches/plans or indicate resolution of difficulties related to treatment and discharge planning.

3. South Beach should develop a procedure for following up on patients who are discharged and whose plans for aftercare do not include attendance at a South Beach Psychiatric Center outpatient clinic. While it is recognized that SBPC has established a liaison system with its outpatient clinics to ensure a smooth transition from inpatient to outpatient care, it was evident, as in the case of G.D., that patients are at times discharged with plans to attend non-SBPC outpatient clinics. In such cases, SBPC should follow up to ensure that the plans are implemented.

4. Given the idiosyncratic problems noted during the review of 14 instances of restraint and seclusion, South Beach Psychiatric Center should initiate a process for conducting ongoing audits of restraint and seclusion

practices for the purposes of providing feedback to Units and counseling and training for staff whose performance in this area is less-than-adequate. Such an audit process relative to discharge practices is apparently working quite well.

Additionally, South Beach should reiterate to staff the standards for and importance of monitoring vital signs of patients in restraint or seclusion.

5. South Beach should take steps to correct conditions in the seclusion rooms on the Sheepshead Bay and Structured Treatment Units and to install electronic temperature gauges in the seclusion rooms on the BARS Unit.

6. The Commission recommends that the Office of Mental Health should expedite the promulgation of statewide policies regarding the availability and inspection of emergency medical equipment and staff preparedness on its use.

NEW YORK STATE
OFFICE OF MENTAL HEALTH 44 Holland Avenue, Albany, New York 12229

STEVEN E. KATZ, M.D., Commissioner

June 6, 1984

Honorable Clarence J. Sundram
Chairman
State of New York
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 730
Albany, New York 12210

Dear Mr. Sundram:

Thank you for providing an opportunity to respond to the Commission's Confidential Draft on "A Follow-up of Implementation of Commission Recommendations to Improve Care: South Beach Psychiatric Center". It is gratifying to note the Commission's positive finding "...that there was little evidence that previously cited inadequacies still exist".

Be assured that the Center's director, Lucy Rea Sarkis, M.D., and her staff will continue to strive for additional improvement in those areas cited in the draft report. The report was reviewed by the facility, the New York City Regional Office and the Central Office staffs. Our comments on its recommendations are as follows:

With regard to the report's first recommendation, calling for a review of the BARS Unit staff's compliance with the Office of Mental Health's record keeping policies and procedures, the Center will conduct a three-week refresher training program on the use of the Uniform Case Record for such staff beginning June 11, 1984. The program will be provided by the facility's Education and Training department and the Director of Medical Records. Group training and individual assistance will be provided. The facility also notes that for about a year the BARS Unit had been without a full-time medical records supervisor until this past April when a new person was hired. This important additional resource is now available to the clinical staff on the Unit as well as providing the administration with enhanced monitoring capabilities.

Concerning the report's second recommendation, on the need to document in patient records decisions made in daily treatment team meetings, South Beach Psychiatric Center policy is that such documentation preferably occur immediately but no later than in weekly progress notes. In addition to the previously mentioned UCR training Refresher Program on the BARS Unit, South Beach Psychiatric Center is instituting a six-week program in which Chiefs of Service will audit medical records. The audit began May 21 and will continue through June 29, 1984. Included in this audit are areas mentioned in Commission's report.

South Beach Psychiatric Center concurs with the recommendation of the Commission to develop a procedure for following up on patients who are discharged and whose plans for aftercare include attendance at outpatient clinics other than those operated by South Beach Psychiatric Center. Henceforth, when such a patient is discharged, a letter with a stamped addressed envelope and a verification form will be sent to the receiving treatment facility, with a request that the facility notify South Beach Psychiatric Center in writing, regarding any patient's failure to appear for treatment. In addition, South Beach Psychiatric Center inpatient staff will call the receiving facility immediately following the patient's scheduled appointment to verify that the appointment was kept. In the event that the first aftercare appointment is missed, South Beach Psychiatric Center will then take responsibility for contacting the patient by telephone or by mail, and where necessary in person, to encourage the patient's appearance at the after care program or to make an alternate arrangement where clinically indicated.

With regard to recommendation four, concerning audits of restraint and seclusion practices, the facility has initiated a multi-level review system of all incidents of restraint or seclusion. Initially, each case of restraint or seclusion is presented to the office of the Deputy Director for Clinical Services (DDC) for review of clinical appropriateness and documentation of adherence to correct policy and procedures. If any error in documentation is noted, the professional in question is immediately informed and counseled by the Deputy Director for Clinical Services.

On the issue of emphasizing to staff the importance of monitoring the vital signs of patients who are in restraint or seclusion, the facility reports that the Director of Nursing will be doing just that in an upcoming Nursing Forum and a follow-up Nursing Audit that will be conducted between July 2 - 6, 1984. In addition, it will be emphasized in the bi-monthly audits performed by the Program Evaluation Department of Quality Assurance. Incidents of non-compliance with policy and procedures by any professional will be immediately dealt with by the Deputy Director for Clinical Services in the form of counseling or further training.

With regard to recommendation number five, concerning conditions in seclusion rooms, the structural problems in the Sheepshead Bay Unit have been corrected. Regarding electronic thermometers for the Brooklyn Admitting Units, hand held digital electronic thermometers have been ordered and delivery is anticipated before June 30, 1984.

We concur with the Commission's recommendation number six: "to expedite the promulgation of a statewide policy regarding availability and inspection of emergency medical equipment and staff preparedness on its use". The Office of Mental Health has made emergency medical services systems (EMSS) a priority concern. The first draft of a policy on EMSS will be sent to the field for review this summer. Inspections and use of emergency equipment will be an important part of this program.

Again, my thanks for providing us with an opportunity to comment on the Commission's Confidential Draft Report. We would be pleased to provide you with any additional information that you may require.

Sincerely,

Steven E. Katz, M.D.
Commissioner