A Review of

SELECTED ASPECTS OF PATIENT CARE:

Manhattan Psychiatric Center

1979–81

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

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PREFACE

This review of conditions at Manhattan Psychiatric Center is an outgrowth of the work of the Mental Hygiene Medical Review Board, a statutory component of the Commission. The Board's review of patient deaths at Manhattan Psychiatric Center in 1979 raised a number of questions regarding management and treatment practices at the facility. As a result, in June of 1979, the Commission initiated an indepth review of the care provided to all 60 Manhattan Psychiatric Center inpatients and outpatients who died during the previous 15 months.

The Commission shared its findings with the Office of Mental Health and Manhattan Psychiatric Center in April 1980. Subsequently, a plan of correction was developed and implemented and Commission staff conducted a follow up of its implementation during 1980 through a second indepth review of conditions at Manhattan Psychiatric Center.

A draft of this final report has been reviewed by the Office of Mental Health, and the Manhattan Psychiatric Center. The responses to our recommendations have been incorporated following the recommendations.

The findings, conclusions and recommendations of this report represent the unanimous opinion of the Commission. We are pleased that our follow-up study indicates significant strides have been taken by Manhattan Psychiatric Center to effectuate changes in these vital areas of patient care and treatment. We urge the continuation of this momentum to initiate the remaining changes we believe are essential.

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

As a major provider of mental health services, providing care and treatment for 1300 inpatients and 1100 outpatients, Manhattan Psychiatric Center (MPC) has experienced many changes in recent years. Some of these changes have been prompted by factors affecting the mental health system as a whole. Evolving philosophies of care and changing standards for accreditation of services, for example, have prompted major reorganizations of patient services and administrative structures at MPC and most of New York State's psychiatric centers.

The impetus for other changes at MPC, however, has been this Commission's review of conditions at the Center -- a review which has spanned the course of three years. This report reflects conditions found during the Commission's initial and follow-up review activities, chronicles the changes prompted by those activities, and offers suggestions for future action both to sustain the momentum of positive change in certain aspects of MPC's operations and to initiate such changes in others. Since the factors that affect the quality of care at any psychiatric center -- patient census, availability of staff and other resources, etc. -- are constantly in a state of flux, the report does not purport to represent conditions as they exist at present.

Nature and Scope of Commission Review

The Commission's review of conditions at Manhattan Psychiatric Center was an outgrowth of the work of the Mental Hygiene Medical Review Board which, in its review of certain patient deaths at MPC, raised a number of questions

regarding management and treatment practices at the facility.* As such, in June 1979, the Commission initiated an indepth review of the care provided all of the 60 inpatients and outpatients of the Center who died during the previous 15 months.

This review revealed problems in general treatment and medical care, including restraint and seclusion practices, discharge practices, the granting of home leaves and grounds privileges, and internal monitoring at the facility. The Commission shared its findings and recommendations with the administration of MPC and the Commissioner and senior staff of the Office of Mental Health in April 1980. During the summer of that year, agreement was reached regarding a plan of correction and a timetable for the amelioration of problematic conditions at the facility.

In monitoring the implementation of corrective actions, Commission staff in 1981 again conducted an intensive review of conditions at MPC. In this endeavor the records of approximately ten percent (16 cases) of the patients admitted to the facility in May 1981 were reviewed. Commission staff also reviewed the records of ten percent (17) of the patients discharged and 50 percent of the patients who expired or were transferred to acute medical care facilities in May 1981. Additionally, records pertaining to restraint and seclusion and certain administrative committees were reviewed and direct care and senior administrative staff were interviewed.

Findings

Generally, the Commission's follow-up review of conditions at the Center indicated that MPC has acted on a number

*A statutory component of the Commission, the Mental Hygiene Medical Review Board is charged with the responsibility of reviewing unnatural or unusual deaths of inpatients and outpatients of mental hygiene facilities.

of the recommendations stemming from the Commission's 1979 review, and that MPC's initiatives have, in many respects, led to an improvement in patient care. Other initiatives of the Center, however, have not been broad enough in scope and, as such, in certain areas the quality of patient care has been left unchanged or has seen little improvement.

With regard to the general quality of patient care, for example (pages 3 to 17), the Commission noted improvement in the care afforded patients who, by virtue of their violent behavior or multiple disabilities, were particularly vulnerable and posed considerable treatment challenges for staff. The initial review in 1979 revealed that MPC had no special resources to deal with violent patients and that these patients, who posed dangers to themselves and those around them, were placed on wards with the general population. Without the benefit of special resources to meet the needs of this special population, restraint or seclusion was often used as a means of managing behavior problems. In fact, the initial review revealed cases in which patients were placed in seclusion for 24 and 40 hour periods. The follow-up review, however, indicated that MPC's creation of an Intensive Psychiatric Unit with an enriched and specially trained staff, as recommended following the initial review, had improved the care afforded individuals whose behavior pose dangers to themselves or others. Unannounced Commission staff visits to this unit revealed a clean, wholesome and well-appointed environment and patients actively involved in therapeutic activities. Commission staff also found a reduction in the period of time patients spent in restraint or seclusion. Similarly, the Commission's follow-up activities revealed an increased attentiveness, through assessment and treatment, to those patients who, by virtue of secondary disabilities such as alcoholism or substance abuse, posed unique treatment challenges.

While the longitudinal review indicated improvements in the quality of patient care in some areas, it also indicated room for improvement. Commission follow-up activities revealed non-compliance with policies concerning documentation of restraint and seclusion practices, and the granting of home leaves or grounds privileges. The follow-up review also revealed the need for a re-examination of the role and supervision of direct care staff to foster their participation in programmatic activities.

Medical care at the Center, which was a subject of the Commission's initial and follow-up reviews, also evidenced improvement and the need for further action on the part of MPC (pages 18 to 22). Commission staff found that MPC had taken actions to improve communication among staff and to enhance the resources of the medical staff, and as a result had increased its responsiveness to the medical problems of patients. However, the follow-up review also indicated that patients included in the sample did not receive certain routine medical examinations as prescribed by Office of Mental Health policies, thus indicating the need for increased attentiveness to routine preventive medical care. The follow-up activities also indicated that MPC's attempts to train all staff in certain emergency medical procedures, namely the Heimlich maneuver and cardiopulmonary resuscitation, had met with little success. Although this was not due to a lack of a good faith effort on the part of MPC, it indicates the need for a re-examination of MPC's training activities.

It was also found that, while MPC endeavored to improve the process of discharging patients and linking them with appropriate aftercare services, its initiatives in this regard have not been broad enough in scope (pages 23 to 29). Through the establishment of a liaison system with the

Department of Social Services and the assignment of case managers to monitor discharged patients, the Center has facilitated the successful transition of certain patients to the community. However, the follow-up review indicated that not all patients discharged from the Center -- namely those referred to non-MPC aftercare clinics -- receive the benefit of these initiatives. As found during the initial review, certain discharged patients are left to face the challenge of integration into the community alone, with no agency monitoring the success of the transition. The follow-up review also revealed MPC's non-compliance with polices regarding the referral of patients to aftercare services upon discharge.

During the course of its review, the Commission noted significant improvement in MPC's internal monitoring through its incident reporting and review process (pages 30 to 32). The initial review indicated the deliberations of MPC's Special Review Committee, which is charged with reviewing incidents at the facility, were often untimely and more academic than practical. Moreover, the Committee lacked any mechanism to follow up recommendations to prevent the recurrence of incidents. Upon our follow-up review, it was found that the composition and functioning of this Committee had been improved and that the Committee, through its timely review of incidents and follow-up of recommendations, has become a viable internal monitoring mechanism.

Recommendations

Recognizing the achievements made by MPC staff in upgrading patient care and also their desire to improve upon these significant initial steps, the Commission recommends that:

1. Manhattan Psychiatric Center assign top priority to the expressed need of Intensive Psychiatric Unit staff for refresher training in techniques for managing violent or assaultive patients.

2. Manhattan Psychiatric Center assess the various approaches of its inpatient units to address the secondary disabilities of patients. While Center officials reported that such disabilities are most appropriately treated on an outpatient basis, it was found that certain staff had initiated treatment on an inpatient basis. One unit has even arranged for a community based treatment facility to conduct treatment on the inpatient ward. The assessment of the various inpatient staff attempts at treating secondary disabilities can lead to:
   (a) an identification and pooling of resources available for treatment;
   (b) center-wide implementation of those more creative treatment approaches being implemented on specific wards;
   (c) an augmentation or enrichment of on-ward programs; and
   (d) more timely linkages to the community service network for those patients who will be discharged, to the extent that certain approaches incorporate community based services.

3. To enhance the level of programming on the wards, Manhattan Psychiatric Center should review the role and supervision of direct care staff. This review should focus on possible strategies to increase direct care staff participation in programming, and supervision of such staff. Possible strategies to be considered should include:

(a) The assignment of therapy aides to specific patients, not only for such indirect patient care activities as "charting," but for participation in the more direct patient care activities, such as assisting activity specialists or rehabilitation specialists in conducting programming. The perception that therapy aides participate in programming on a "voluntary" basis must also be addressed.

(b) Consideration should also be given to the creation of a centralized pool of staff to engage in escort services. It is hoped that this will result in a more effective utilization of the already limited resources and a lessening of disruptions of scheduled ward activities.

4. It is recommended that individual instances of the use of restraint and seclusion and the granting of home leaves and grounds privileges be reviewed periodically on a sample basis by the Quality Assurance Division. Reports of specific deficiencies noted should be sent to the units involved for appropriate action, and reports of the scope and nature of facility-wide deficiencies should be sent to the Center's administration for remediation through broad-based interventions, such as increased training and policy directives.

Although Commission staff noted a generally improved responsiveness to the medical needs of MPC patients, particularly when they complained of problems, the continuing deficiencies in routine medical practices, such as the lack of routine medical examinations, found by the Commission, as well as the continuing need to ensure proficiency in medical emergency procedures indicate that:

5. Manhattan Psychiatric Center must redouble its efforts to ensure that all patients receive mandated routine medical examinations, including not only the annual physical examination required for all patients, but also those specialized examinations required for certain patients on the basis of their age and sex. In attempting to ensure that all patients receive mandated medical services, MPC should involve and utilize its patient advocacy network by informing advocates of the nature and frequency of the services which are to be expected. Such advocates include not only the patient's family, but the Center's Board of Visitors and other Center-affiliated advocacy groups, as well as all direct care staff who, constituting the front line of the care delivery system, are in daily contact with the patient and his/her record of services.

6. The Center should also revitalize its initiative to train all staff in emergency medical procedures, particularly those techniques dealing with cardiopulmonary resuscitation and obstructed airways. It is therefore recommended that, upon the recruitment of appropriate training staff, the Center initiate a review of earlier training activities for the purpose of identifying factors contributing to their failure. On the basis of this review, the Center should initiate a revised program of training designed to ensure that all staff are proficient in cardiopulmonary resuscitation and the Heimlich maneuver. It is also recommended that the Commission, the Regional Office and the facility's Board of Visitors receive copies of the findings of the facility's review of factors contributing to the limitations of earlier inititaives in training, as well as copies of the training curriculum for the revised program of training in emergency medical procedures.

While Manhattan Psychiatric Center has attempted to establish a system of monitoring patients during the period of transition from inpatient to outpatient care, which has improved the linkages to outpatient services provided by MPC, the Commission's review indicates that MPC's initiatives are far too limited in scope and that patients referred to non-MPC aftercare services are still left to negotiate a complex community based care system without adequate support or follow-up. Approximately 50 percent of the patients in the sample of discharged cases were referred to non-MPC clinics. As such, it is recommended that:

7. Manhattan Psychiatric Center initiate a system to ensure that all discharged patients arrive at the residences to which they were discharged. The decision to actually accompany the patient to the residence should be based primarily on considerations of the patient's clinical condition and the proposed residential arrangement rather than the geographic location of the residence and public assistance status of the patient. At the time of discharge, the decision to ensure the patient's arrival at the planned residence by accompanying him/her or by following up in another fashion should be documented as well as the method, parties responsible and time frames for follow-up.
8. In addition to ensuring that patients are settled into the residential settings arranged prior to discharge, MPC must also ensure that plans for aftercare services are followed up. Toward this end it is recommended that:

   (a) MPC should adhere to Regional Office policies and ensure that all patients receive a

scheduled appointment for outpatient services within five days of discharge.

(b) MPC should also initiate a system to ensure that all patients actually keep their first clinic appointments. While efforts to follow up on patients who have failed to keep scheduled appointments may fall to outpatient staff of MPC or staff of clinics operated by other agencies, in the Commission's opinion it is incumbent upon MPC to monitor the implementation of discharge plans for all patients.

(c) In an effort to ensure a uniform system for follow-up of discharged patients, MPC must first address the differences among its own clinics with regard to patients who fail to keep scheduled clinic appointments.

(d) To the extent that non-MPC operated clinics are utilized as providers of outpatient services for individuals discharged from MPC, it is imperative that MPC negotiate with these clinics and establish a methodology for follow-up, with clear definitions of responsibility for patients who fail to keep their outpatient appointments. While MPC should take the initiative to establish a system for follow-up, it is recognized that the effectiveness of such a system is contingent upon the cooperation of a number of non-MPC operated clinics in the Metropolitan area. Therefore, it is further recommended that the Regional Office play an active role in the development and monitoring of a system for ensuring the follow-up of patients discharged from MPC.

(e) Finally, the Commission recommends that outpatient clinics receive documentation regarding the medications supplied to patients upon discharge from MPC so that these medications, as well as the patient's overall clinical condition, may be taken into consideration in prescribing practices on an outpatient basis.

INTRODUCTION

The Commission's review of conditions at Manhattan Psychiatric Center was an outgrowth of the work of the Mental Hygiene Medical Review Board. A statutory component of the Commission, the Medical Review Board is charged with the responsibility of reviewing unnatural or unusual deaths of inpatients and outpatients of mental hygiene facilities.

In the course of its review of such deaths at Manhattan Psychiatric Center (MPC), the Medical Review Board raised a number of questions regarding management and treatment practices at the facility as these were reflected in the care of the patients reviewed. In June 1979 the Commission initiated an indepth review of the care provided all of the 60 patients of the Center who died during the previous 15 months. (See Appendix 1 for tabular displays of patient death data.)

Approximately 115 Commission staff days were spent on inpatient wards and at outpatient clinics reviewing records and interviewing direct care staff. Additionally, senior administrators of Manhattan Psychiatric Center, staff of the Mental Health Information Service, and members of various advocacy groups affiliated with the Center were interviewed. This review revealed problems in general treatment and medical care including restraint and seclusion practices, discharge practices, the granting of home leaves and grounds privileges, and internal monitoring at the facility.

The Commission shared its findings and recommendations with the administration of MPC and the Commissioner and senior staff of the New York State Office of Mental Health in April 1980. In the summer of 1980, agreement was reached regarding a plan of correction and a timetable for the amelioration of problematic conditions at the facility.

In monitoring the implementation of corrective actions, Commission staff in 1981 again conducted an intensive review of conditions at MPC. In this endeavor the records of approximately ten percent (16 cases) of the patients admitted to the facility in May 1981 were reviewed. Commission staff also reviewed the records of ten percent (17) of the patients discharged and 50 percent of the patients who expired or were transferred to acute medical care facilities in May 1981. As in the initial review, records pertaining to restraint and seclusion and certain administrative committees were reviewed during the Commission's follow-up activities, and direct care and senior administrative staff were interviewed.

The subsequent chapters of this report detail the original and changing conditions found during the course of the Commission's review regarding:

- General treatment issues;
- Medical care;
- Discharge practices and community based care; and
- Internal monitoring.

The final chapter, Conclusion and Recommendations, offers suggestions for future action to sustain the momentum of positive change witnessed by the Commission in certain aspects of MPC's operations and to initiate such change in others.

Chapter I

GENERAL TREATMENT ISSUES

The initial review of the 60 deaths at MPC revealed the complex treatment challenges presented to staff at the Center. For example, 19 of the 60 cases reviewed were patients who had committed suicide. A majority of these had disabilities secondary to their psychiatric disability: eight had histories of drug abuse, two were alcoholics, two were mentally retarded and one was mentally retarded as well as a substance abuser. Many of these patients were described as "difficult," a term used by MPC staff to describe behavior that was either extremely demanding, agitated, impulsive, self-abusive or abusive toward staff or other patients. The vulnerability of these patients, the complexity or multiplicity of their problems, and their sometimes dangerous behavior presented a treatment challenge for which the Center was found to be poorly prepared at the time the Commission initiated its review in 1979. However, the Commission's continuing review indicates that MPC's responsiveness to this challenge has significantly improved in a number of ways since that time.

Treating the Violent Patient

When the Commission initiated its review, MPC had no special resources to deal with the violent patient or the patient whose behavior posed a danger to himself or others. There was no special unit to provide care for this type of patient, no special allocation of staff or ongoing training for staff in the management of violent patients. Rather, such patients were placed on wards with the general population; and staff there, without the benefit of special training or increased support, through augmented staffing patterns, had difficulty in meeting the patients' needs.

Michael C. illustrates the challenge faced by the staff and the lack of resources necessary to meet that challenge:

> Diagnosed as paranoid schizophrenic with a history of drug abuse, Michael was committed to the Center as incompetent to stand trial following a robbery. For one month of his three-month stay he was almost continuously agitated and was described by staff as dangerous, volatile and unpredictable. One senior staff member indicated that as far as being dangerous was concerned, Michael was a "9" on a scale of 1-10. Despite this patient's behavior and the staff's fear of him, there was no alternative but to treat him on a general ward. Michael escaped and committed sucide. On the day of his escape, only three direct care staff were scheduled to care for Michael and the 29 other patients on his ward. Two of these failed to report to work and were replaced by therapy aides who worked overtime. There was no evidence that any of the staff on the ward had training to effectively manage the kind of behavior exhibited by Michael.

In the absence of any special unit or sufficient staff to provide the close supervision some patients required, restraint or seclusion was often used as a means of managing the behavior of patients like Michael. Michael, for example, spent as much time in a seclusion room as he did out of one during the month that he was extremely agitated. Often patients were placed in seclusion for extended periods of time and the Commission's initial review revealed cases of individuals placed in seclusion for periods of up to 24 and even 40 hours.

While restraint or seclusion is occasinally clinically necessary, it is recognized as a radical intervention and as such, its use is governed extensively by laws, regulations

and procedures designed to deter the abuse of these interventions. (See Mental Hygiene Law §33.04.) The Commission's initial review indicated that in attempting to manage the behavior of patients through the use of restraint or seclusion, MPC staff generally failed to follow these guidelines:

-- In contrast to the Mental Hygiene law, which indicates that under no circumstances shall protective restraints or seclusion be used as punitive measures, or for the convenience of staff, or as a substitute for programs, MPC staff reported that decisions to place a patient in seclusion were often made to maintain order on the ward, particularly when staff was limited. In direct violation of OMH policies, it was found that in a number of cases "seclusion as needed" orders (PRN) were issued by doctors. This meant patients could be placed in seclusion at the discretion of ward staff without the benefit of an examination by a physician as required by the policies.

-- Required documentation regarding the rationale for the use of seclusion (physician's orders) was often missing or incomplete as was documentation regarding mandated periodic obsevations of the patient in restraint or seclusion.

-- There was no documentation that the cases of patients kept in seclusion for extended periods of time were reviewed by senior clinicians although such reviews were required by MPC policies.

In light of these findings, the Commission recommended a number of actions to be taken by MPC to improve the care and treatment of difficult to manage patients. Specifically, the Commission recommended the creation of a special

unit to serve this population at MPC and the allocation of staff with training specific to the needs of the population to work in the unit. The Commission also recommended that MPC staff adhere to the laws, regulations and procedures governing the use of restraint and seclusion and that ongoing training be provided staff in this area. The Commission further recommended that in monitoring patients in restraint or seclusion, special attention should be paid to the patients' vital signs, food and fluid intake and the environmental conditions (temperature and ventilation) of seclusion rooms.

In monitoring MPC's implementation of the Commission's recommendations during the fall of 1981, it was found that the treatment afforded patients whose behavior presents a significant challenge to staff has improved markedly.

In December 1980, as recommended by the Commission, MPC opened an intensive psychiatric unit of 15 beds. With a 1:1.2 staff/patient ratio, the unit is designed to provide a specialized treatment milieu for those patients who, because of their behavior, cannot be maintained on general wards. Recent Commission reviews of the conditions and operations of this unit indicate that the unit is achieving its goals and objectives: active treatment is offered and patients' acute symptoms are usually ameliorated within three weeks of admission to the unit, thereby allowing continued treatment in a less restrictive ward setting.

During unannounced site visits to the unit, Commission staff were impressed with the programming witnessed -- calisthenics, art projects, etc. -- and the general conditions found. The unit was brightly painted, tastefully decorated, furnished and personalized with patients' own art work. Commission staff also found that in addition to the training in restraint and seclusion afforded all MPC staff,

staff assigned to work on the Intensive Psychiatric Service had received specialized training in handling the population to be served by that unit prior to the unit's opening. However, citing the fact that the training was offered in 1980 and that there had been some turnover in staff since then, this unit's staff indicated the need for periodic refresher courses.

The Commission's follow-up activities also indicated an increased adherence to laws, regulations and policies governing the appropriate use of restraint and seclusion. It was the impression of Commission staff that these interventions were used less frequently and when used, were used sparingly.

During the follow-up review, Commission staff intended to review the records and conditions of five patients in restraint or seclusion at the time of our follow-up visits to the facility. However, during the unannounced follow-up visits, in contrast to the findings of the initial review, it was difficult to find patients in restraint or seclusion. Commission staff therefore reviewed the cases of five patients who were placed in seclusion in the recent past. In contrast to our earlier findings, the records contained clear rationales for the need for seclusion, signed physicians' order sheets, and completed observation sheets. In marked contrast to the Commission's initial review, which revealed patients being kept in seclusion for more than 24 hours, the follow-up review indicated that none of the patients were restrained or secluded for more than two hours.

While improvements in the utilization of restraint and seclusion were noted, the follow-up review indicated continuing deviations from current regulations and policies governing the use of these interventions. There was no

documentation indicating that patients received a physical exam by a physician prior to being placed in seclusion, nor was there documentation that staff monitored patients' vital signs as required by OMH policies and procedures.*

In summary, however, while continuing deficiencies were noted in restraint and seclusion practices, the Commission found the care and treatment afforded difficult to manage patients at MPC greatly improved.

The Multiply Disabled Patient

Improvements in the care afforded multiply disabled patients were also noted during the course of the Commission's three-year review. As previously mentioned, more than half of the individuals included in the Commission's review of deaths at MPC who committed suicide had multiple disabilities. Yet the Commission's initial review revealed little evidence that secondary disabilities were taken into consideration in treatment planning for the patients. The case of Mary L. illustrates this point.

> When Mary L. was admitted to MPC it was known that she was an active patient in a methadone maintenance program. A note upon admission indicated that methadone would not be continued, but there was no explanation for that decision. After returns from periodic home leaves, Mary was frequently assaultive and agitated and would have to be placed in seclusion. Staff members thought that she had been abusing drugs while on leave. Shortly after spending several days in seclusion,

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*Office of Mental Health Policy Manual, sections 7600 C.1.c. and 7600 D.2.a.

> Mary L. left the hospital without consent. She returned two days later to pick up her clothes and was discharged at her own request to the care of an acquaintance whom staff believed to be supplying her with drugs. Despite her past history of substance abuse, the termination of substance abuse services upon her admission to MPC and staff suspicions that she was abusing drugs while on leave, there was no evidence of any attempt to link Mary with a drug treatment program upon discharge.

Similar cases uncovered during the review of deaths at MPC prompted the Commission to recommend that MPC identify patients with secondary disabilities and ensure that treatment plans provide for the appropriate care of patients' secondary handicaps. The Commission's monitoring of conditions at MPC indicates that MPC has made substantial progress in identifying and treating, directly or through referral, patients' secondary disabilities.

The Commission's follow-up review of ten percent of admissions to MPC in May 1981 focused on MPC's actions regarding secondary disabilities. Of the 16 patients included in the sample, 14 had secondary disabilities. Thorough assessments, completed by MPC staff at the time these patients were admitted, noted the presence of or potential impact of the secondary disabilities in all 14 cases. MPC has also sought and received licensure to dispense methadone, thereby ensuring the possibility of continued methadone maintenance for patients who, like Mary L., were receiving such treatment prior to admission to the Center.

While senior staff at MPC indicated that secondary disabilities are most often and more appropriately treated post-discharge, there was evidence of attempts to treat the

secondary disbility during the course of inpatient treatment in 29% of the cases reviewed. For example, one of the patients in the sample was involved in a weekly group therapy session for substance abusers conducted on his inpatient unit (CTV VI) by a community based drug treatment agency. In another instance, inpatient staff (again CTV VI) delayed the discharge of a patient who was refusing all treatment referrals (including alcohol and substance abuse treatment) to allow additional time to motivate the patient to accept services. While it may be appropriate to treat secondary disabilities on an outpatient basis, the Commission review indicated that such treatment in certain cases was initiated on an inpatient basis, and the Commission believes that MPC could further capitalize on the creativity shown by certain staff in providing such treatment on an inpatient basis.

It was also found that when a number of the patients with secondary disabilities in the follow-up review sample were discharged, MPC staff exhibited their attentiveness to the secondary disabilities by making referrals to appropriate substance or alcohol abuse treatment settings or by communicating the need for treatment of the secondary disabilities to psychiatric outpatient clinics. Ten of the 14 patients with secondary disabilities had been discharged by the time of the Commission's follow-up review. In all but one case, appropriate referrals to services or communication of need for services for the treatment of secondary disabilities were made. In contrast to the findings of the initial review, the follow-up review revealed instances where MPC staff went to great lengths to link patients with services appropriate to their secondary disabilities upon discharge. The case of Mary M. is a good example.

Mary's inpatient treatment team realized that this 61-year-old woman suffered from bouts of depression and loneliness and abused alcohol at such times. They were also aware of the fact that her drinking aggravated her psychosis and resulted time and again in her readmission. In an effort to break this cycle, staff ensured that upon discharge Mary would reside in a supervised setting which had not only socialization activities on site, but an Alcoholics Anonymous program as well. Staff also made arrangements for day treatment sevices and generally attempted to ensure that Mary had the structure and social network to help minimize conditions which contributed to her psychiatric compensation.

Other Treatment Issues

While the Commission's longitudinal review of changing conditions at MPC has revealed improvements in the treatment of patients whose behavior or multiplicity of disabilities present unique treatment challenges, recent review activities have indicated the need for additional attention to the treatment needs of the general patient population.

In the initial review of the 60 patient deaths at MPC, the Commission was critical of the "lack of a sense of responsibility" on the part of direct care staff toward specific patients -- an absence which made it not only difficult for MPC staff to get to know the patients and participate in their treatment, but difficult to keep track of patients' whereabouts. As such, the Commission recommended that MPC assign responsibility for specific patients to individual therapy aides -- a recommendation intended to stimulate both greater direct care staff participation in the patients' treatment and increased supervision of and

accountability for direct care staff activities. MPC officials indicated at that time that the "Murray Hill Unit" of MPC had a system of assigning responsibilities for specific patients and that at the completion of a planned managerial and administrative reorganization at MPC, the Commission's recommendation for a facility-wide program similar to Murray Hill's would be considered. MPC also indicated that the planned reorganization, which was intended to better align resources to patient needs, would enhance supervision.*

The Commission's ongoing review activities at MPC revealed, however, that MPC has not reconsidered the Commission's recommendation of specific staff/patient assignments; that reorganization has not in actuality achieved a

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*As part of its overall strategy to improve care for the mentally ill, the Office of Mental Health had, subsequent to the Commission's initial review, initiated a major reorganization of patient care services within its psychiatric centers. Where formerly patient services were organized on a geographic unit basis -- that is, treatment teams and units were organized to serve particular catchment areas -- the reorganization was initiated to align treatment services to the functional needs of the patient regardless of his or her place of residence.

The initiative called for organizing patients into three broad functional groupings, reflecting their level of care needs and the reorganization of treatment teams to meet the needs of the various levels of care. This reorganization was intended to provide not only a more planned approach to patient needs and distribution of resources, but a statewide consistency in the organization of services in psychiatric centers. It was also intended to reflect the organizational structure of the general health industry which has acute, skilled, intermediate and domiciliary levels of care.

significant redistribution of resources reflective of the functional needs of patients; that programming for patients is variable among the units; and that direct care staff participation in programming is often left to their own discretion.

In interviews during the Commission's follow-up activities, the clinical director at MPC professed having no knowledge of the status of the implementation of the Commission's recommendation for patient specific staff assignments. He reported that the Murray Hill Unit ceased to exist after the recent reorganization and that unit chiefs of the new functional units have discretion over the manner in which staff are assigned. He also indicated that he did not know of the different practices of unit chiefs in this regard. Commission staff interviewed the former unit chief of the Murray Hill unit, currently a unit chief for one of MPC's functional units. In this interview it was found that staff on her unit are still assigned to specific patients. In visits to other units it was found that this practice varies and that patient specific staff assignments are, in certain units, limited only to non-direct care activities such as recordkeeping.

The visits to the units also revealed that, in actuality, reorganization has not achieved a significant redistribution of direct care resources reflective of patient needs and that programming for patients, and staff participation in such programs, is variable among the units.

On October 15 and 16, 1981, between the hours of 9-11:30 a.m. and 1-3:00 p.m., Commission staff conducted unannounced site visits to 14 wards at MPC for the purpose of assessing the adequacy of staffing levels and the level of programming being received by patients. Seven of the

wards visited were components of Comprehensive Treatment Units (CTU), designed to serve as admission units for the acutely ill. Four wards visited were sub-units of Social Rehabilitation Units (SRU), designed primarily to serve regressed chronic patients. The final three wards visited were components of Extended Care Units (ECU), or service units designed for patients requiring skilled nursing care.

While the wards visited were designed to serve distinctly different populations, this variability was not reflected in the overall distribution of direct care staff at the time of Commission visits. As reflected in the table in Appendix 2, the direct care staff to patient ratio on the wards of the three units visited differed only fractionally.

While the level of direct care staff differed slightly unit to unit, and the greatest variability among units was the level of direct care nursing staff coverage, the variability in programming on the wards visited was striking. As indicated in Appendix 3, the majority of ECU patients (61%) were involved in programs at the time of the Commission's visits, despite the fact that this level of care had fewer direct care staff assigned. Over all, 51% of the patients on the wards visited were engaged in no activity. The highest percentage (61%) of patients without activity occurred in the Social Rehabilitation Units.

While apparently minimal staffing levels understandably contribute to the lack of activity (on one ward of 25 patients -- SRU III 11A -- there were only two therapy aides present during the Commission visit; one was "charting" and one was preparing to escort a patient to the clinic), the

Commission's review of direct care staff activities indicates that factors such as role definition and supervision of direct care staff may also contribute to less than optimal use of the staff available.

At the time of the visits a total of 54 direct care staff (45 therapy aides and 9 nurses) were present to care for the 466 patients in the 14 wards visited. Most, as indicated in the table in Appendix 4, were engaged in activities related to patient care:

-- 22 percent were supervising patients; i.e., intervening in patient disagreements or overseeing patients in day rooms;
-- 22 percent were escorting patients to various clinics or running errands;
-- 14 percent were administering medications, checking blood pressures or observing patients on suicide precautions;
-- 11 percent were engaged in paperwork; and
-- 4 percent were engaged in "community meetings" on the ward while 7 percent were on lunch or coffee breaks.

However, approximately 19 percent of the available direct care staff pool on the wards visited were not engaged in patient activities. Four staff were observed talking to each other and six staff could not be found on their designated wards by Commission staff and their whereabouts were unknown by ward staff. In addition to a signficant segment of the work force being found not engaged in patient care, those staff who were engaged in some form of patient care activity -- overseeing patients in a day room, etc. -- reported to Commission staff that they do not participate in more active programming -- usually conducted by activity specialists or rehabilitation staff -- except on a voluntary basis.

Commission staff also reported that while most wards visited were clean and well decorated, most were sparsely furnished and the patients in general were poorly dressed in ill-fitting, mismatched and unattractive clothing. It thus appears that MPC must further improve patient programming, supervision of direct care staff, and clothing supplies for patients.

A final treatment issue examined by the Commission during its initial review of conditions at MPC, and found to be in continued need of attention during this follow-up review, was the lack of documentation of rationales for granting home leaves and grounds privileges. During the Commission's review of the 60 deaths at MPC, little documentation concerning the decision to grant home leaves or grounds privileges was found. Although MPC indicated that its policies require such documentation, the Commission's follow-up review indicated that the policies were not followed consistently.

In reviewing the records of five patients who exercised grounds or home leave privileges at the time of the follow-up study, documentation concerning the decision to grant privileges was completely missing in one case. In fact, the first entry regarding this patient's privileges was made when he failed to return from a home leave. MPC's policies indicate that, as the granting of privileges is considered to be a form of treatment, the decision to grant privileges should be accompanied by a written order from the patient's psychiatrist and documented in the treatment plan and progress notes. In the other four cases reviewed by the Commission, it was found that staff were not consistently following MPC's policies. Documentation regarding the decision to grant privileges was found in some progress notes, or some treatment plans, or on some doctors' order

sheets, but never in all for all the patients. While this is an improvement over what was originally found by the Commission three years ago, it is also an indictor of MPC's need to foster increased staff compliance with policies on this practice.

Chapter II

MEDICAL CARE

Adequacy of medical care at the Center was addressed in the Commission's review of care afforded the 60 Manhattan Psychiatric Center patients who died between the spring of 1978 and summer of 1979. For example, the medical care provided to Gloria B. and Guillemo V. revealed problems in the attentiveness of medical staff to the physical symptomatology of psychiatric patients; in communication among all members of the treatment team; in timeliness of medical interventions, including transfers to community hospitals and in the communication of vital information at the time of such transfers; and in staff proficiency in the performance of medical emergency procedures.

The cause of Gloria B.'s death, for example, was peritonitis and a ruptured ovary. For eighteen days prior to her death she complained of abdominal pains, yet there was no evidence of a physical examination ever being conducted. There was no diagnosis made and on the day of her death a nurse, without doctor's orders, gave Gloria a soapsuds enema. (It is accepted medical opinion that an enema is not a preferred method of treatment when there have been continuing complaints of abdominal pain and no specific diagnosis.)

In Guillemo V.'s case, where the cause of death was asphyxiation, staff attempted cardiopulmonary resuscitation (CPR) when Guillemo collapsed unexpectedly, but there was no attempt to administer the Heimlich maneuver, a method for clearing airways. In interviews with Commission staff at the time these deaths were reviewed, a number of MPC staff

indicated that they had not heard of the Heimlich maneuver, and the Commission questioned the ability of MPC staff to distinguish between a collapse caused by choking and one caused by cardiac arrest -- an important distinction to make prior to administering CPR, as this procedure may cause asphyxiation if there is a partial obstruction of the airway.

In sharing these findings with the administration of MPC, the Commission recommended a number of actions to improve medical care at the facility.

Responsiveness to Medical Problems

During the Commission's follow-up review in the fall of 1981, we found that, in attempting to implement our recommendations, MPC has taken action on a number of fronts to improve its responsiveness to the medical needs of its patients. This finding is based on interviews with MPC officials and a record review of ten patients who expired or were transferred to an acute medical care facility in May 1981.

As recommended by the Commission, communication among all members of the treatment team has improved. MPC had indicated that, in response to the Commission's recommendation, a communication network of intershift reports, communication books and interdisciplinary team meetings would be instituted. In the follow-up review, the Commission found that these avenues had been used by MPC staff in communicating patients' medical needs. Interdisciplinary treatment plans, for example, identified the medical needs and courses of treatment for those patients in the follow-up sample whose medical needs were not of an emergency nature. Similarly, it was found that intershift reports and communication books were used by staff to communicate patients'

daily medical needs and interventions (i.e., physical complaints, transfers, etc.). In response to Commission recommendations, MPC had also recruited a new medical director and an internist for each of its buildings to monitor patients' medical care.

The enhanced communication and enriched medical staff have had a positive impact on medical services at MPC. In all ten cases recently reviewed, it was found that medical staff responded to patients' physical complaints in a timely fashion. In eight of the ten cases, we found appropriate medical intervention, including emergency care, long term care and requests for and follow-up on consultations. In two cases reviewed, however, Commission staff questioned the appropriateness of the medical intervention and these cases will be referred to the Commission's Medical Review Board for further study.

The Commission also found that MPC has, as recommended, improved liaison activities with external medical institutions. Through the initiation of a liaison system with three community based hospitals, MPC has endeavored to ensure that current information (records, progress reports, etc.) is communicated between MPC and the community facilities providing medical care to MPC's patients. The Commission's review of the records of patients in our sample who required outside medical care in May 1981 indicated that the recently implemented liaison system is achieving its objective and tht vital information in these cases was communicated between the facilities.

Special Training and Routine Medical Care

While MPC has made considerable progress in improving medical care by improving communication among team members

and by enriching the medical staff, two areas cited by the Commission as problematic during its review of the 60 deaths appear to warrant continued attention and energy.

In response to the Commission's recommendation that all staff be trained in emergency medical procedures, specifically CPR and the Heimlich maneuver, MPC indicated that a training program would be initiated and, by April 1981, 300 of its 1,822 staff would be trained. The Commission's follow-up activities indicated that MPC made a good faith effort to achieve this objective -- a certified CPR instructor was recruited, a curriculum on CPR and Obstructed Airways was developed and necessary equipment ordered.

The Commission also noted and agreed with MPC's sense of priorities in implementing the program. While the program was designed to ultimately train all staff, MPC attempted to ensure that at least one person from each floor and shift would be trained initially.

The Commission's follow-up activities, however, indicated that MPC's initiative met with little success.

By the summer of 1981 both the CPR instructor and MPC's Director of Education and Training had left MPC's employ and only 175 staff members had completed the training program. It was also found that 100 of the 175 participants in the training program had failed the written CPR certification test and at this time it is unknown if any of those who failed can successfully perform this procedure. During the Commission's review of sample records, however, a case was found in which a therapy aide saved a patient's life using the Heimlich maneuver. Upon further invesigation it was found that this aide had not attended MPC's training program. Thus, it appears that MPC must take further action to identify those staff in need of training in emergency medical procedures and redouble its training efforts.

Problems with routine medical care procedures, cited in the Commission's initial review of 60 deaths, were also found to be continuing during the Commission's follow-up activities. While the review of ten sample cases indicated increased attentiveness to patients' medical needs, particularly when the patients complained of problems, it was found that routine medical procedures were often not performed.

-- 20 percent of the cases reviewed did not have required annual physical examinations and routine diagnostic tests;
-- 50 percent of the individuals in the sample over the age of 45 did not receive annual electrocardiograms as required;
-- 50 percent of the patients in the sample who were over the age of fifty did not receive required examinations for glaucoma; and
-- Two of the five women over the age of 21 in the sample did not receive required gynecological examinations.

In summary, while the Commission's review indicates improvement in medical care at MPC, it was found that patients often do not receive required routine medical examinations.

Chapter III

DISCHARGE PRACTICES AND COMMUNITY BASED CARE

The Commission's initial review of patient deaths at MPC included the deaths of 12 outpatients. The review of these deaths revealed serious problems in the process of discharging patients from the Center. The Commission found that there was no working mechanism to ensure the patients' integration into the community based care network. Often no one at MPC knew where the patient would live following discharge, particularly in those cases where housing was to be arranged by the Department of Social Services. Insufficient information about the patient was transmitted to outpatient services, ill-equipping them to serve the patient adequately. No one at MPC was assigned responsibility to follow the patient from the point of departure from the Center until settlement in the community. There was a lack of follow-up when patients failed to keep outpatient clinic appointments.

It was also found that problems in planning the successful transition of patients to the community were further compounded by the fact that, at the time of the Commission's initial review, MPC's services were organized on a geographic unit basis. That is, treatment units were responsible to provide services to particular patients on the basis of the patient's place of residence. In many instances, however, the residence of the patient to be discharged, and therefore the unit responsible to provide aftercare services, were unknown until the Department of Social Services could arrange housing -- usually on the day of discharge. Sometimes carefully developed plans for aftercare services by a particular unit never came to

fruition because the Department of Social Services arranged the patient's housing within the catchment area of a different unit. With little communication among the treatment units and the Department of Social Services, the patient was left on his own in a new neighborhood to negotiate a complex care system.

In response to the Commission's specific recommendations of steps to be taken to ensure the successful transition from inpatient to outpatient services, MPC outlined the following plan of action:

-- services would be organized on a functional rather than geographic basis and a liaison system with the Department of Social Services would be established;
-- inpatient staff will meet with outpatient staff to the fullest extent possible and social workers will be responsible for transmitting vital information to outpatient clinics; and
-- case managers of the Community Support System team (CSS) will be responsible for following patients and ensuring the implementation of discharge plans.

The Commission's follow-up activities, which included interviews with inpatient and outpatient staff and a record review of 10 percent (17) of the patients discharged in May 1981, indicate that progress has been made toward the successful transition of patients from inpatient to outpatient settings, particularly when the outpatient services are operated by MPC and when the patient receives the services of MPC's liaison system with the Department of Social Services (DSS). However, the Commission's follow-up also

indicate that MPC's initiatives fall short of the desired goals because they do not cover non-MPC operated outpatient services and, as a result, patients still "fall though the cracks" of the community based service delivery system.

Improvements in the Transition to the Community

The functional reorganization of MPC,the initiation of a liaison system with DSS, and the assignment of case managers from CSS to follow patients during the transition from inpatient to outpatient settings has ensured the successful transition of patients to the community setting in a number of ways.

Where, formerly, patients in need of housing were sent to DSS and set up in residences -- their whereabouts unknown to MPC staff -- the new DSS liaison system ensures that MPC staff not only know the location of the new residences of certain of its patients whose housing is arranged by DSS, but actually accompany these patients to their new homes. Essentially, the three MPC staff assigned to the DSS liaison function literally walk patients through the DSS system to the new residences. If DSS cannot find suitable housing, the liaison team member returns the patient to the facility until DSS can find a suitable placement, at which point the liaison team member accompanies the client to the new residence.

The CSS case management system, as it is designed for MPC clinics, is also an improvement over what existed when the Commission first initiated its review of conditions at MPC. According to procedures, CSS case managers are to be assigned to follow-up on patients who fail to keep their outpatient appointments at MPC clinics.

The Commission's follow-up review, however, indicated that the practical application of the procedures varies from clinic to clinic. For example, eight of the 17 discharged patients whose records were reviewed were referred to MPC-operated clinics.* Seven patients actually kept their appointments and as such were not in need of CSS follow-up. The eighth patient, however, failed to report to MPC's 17th Street Clinic. This patient was not followed up by the CSS team. A closer review of the practices of three MPC clinics revealed differences in the vigor and frequency with which CSS teams conducted follow-up on patients. In contrast to what was found at the 17th Street Clinic in the above mentioned example, it was found that CSS staff at the 110th Street Clinic would at times conduct three to four successive home visits when patients failed to keep appointments. At the 125th Street Clinic, home visits were sometimes made when patients failed to attend the clinic. It was also found that this variability was caused by inconsistencies in the practices of psychiatrists at the clinics who determine whether or not patients who fail to keep appointments should be followed up.

In short, the Commission's review indicates that MPC now has a capacity and process to ensure the follow-up of patients discharged to MPC-operated clinics. However, the varying follow-up practices at the clinics need to be addressed.

In the follow-up review of linkages to community based services, the Commission also found an improved coordination

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*Of the remaining sample cases, six were referred to non-MPC operated clinics in the New York City area, two were referred to clinics out-of-state, and one refused all attempts to arrange aftercare services.

of services and attentiveness to the patients' total needs. A review of outpatient records revealed documentation of staff efforts to address, directly or through appropriate referrals, such "total patient needs" as vocational, financial, social, travel training and those needs arising out of secondary disabilities. However, one area in need of increased attention, revealed through Commission follow-up activities, was communication between inpatient and outpatient units regarding medications received by patients at the time of their discharge, and documentation of the supply of medications given. It was reported to the Commission that patients usually receive a two week supply of medication at the time of discharge. However, in reviewing the records of discharged patients, the Commission found little documentation regarding the supply of medications given patients at the time of discharge or whether this supply was taken into consideration when medication was prescribed by the outpatient clinic.

Limitations of Manhattan Psychiatric Center's Initiatives

While MPC has initiated a number of programs and procedures to improve patients' transition to and integration into the community based care system, the Commission's follow-up activities indicate that these initiatives are not far reaching enough and as such many patients are still not successfully settled in the community.

The liaison system with DSS, for example, is designed to serve only those patients who are in need of home relief and who will reside within the catchment area served by the 125th Street DSS office. Therefore, patients who are already receiving public assistance, or who will reside in another social services district, are not accompanied to

their residence by MPC staff. In the Commission's sample of 17 discharges in May 1981, only three patients met the criteria for liaison services and were accompanied to their residences. Of the 14 who were not, one patient failed to arrive at his planned destination. As he took up another residence in a different part of town, all contact with this patient was lost until his decompensation prompted re-admission.

The fact that not all patients are accompanied to their residences -- the first crack in MPC's system of follow-up -- was found to be further compounded by the fact that CSS follow-up activities are limited only to patients referred to MPC clinics. Six of the 17 patients in the discharge sample were referred to the clinics operated by community based hospitals. Three of these patients failed to show up for their appointments and there was no attempt to follow up on their status. MPC similarly failed to follow up on two patients in the Commission's sample who were referred to out-of-state clinics. The 17th patient in the sample refused all attempts to arrange aftercare services.

The Commission's follow-up activities also indicate that the successful transition of patients to the community may be further compromised by MPC's failure to adhere to OMH directives regarding the timeliness of outpatient clinic appointments. A December 13, 1979 directive from the New York City Regional Office of the Office of Mental Health requires that patients be scheduled for their initial out-patient clinic appointments within five days of discharge. Of the 16 patients in the discharge sample for whom after-care services were arranged, only four had appointments

within five days. Of the remaining patients, five had appointments within ten days, one patient's appointment was 15 days post-discharge and six patients were referred to clinics with no fixed appointment dates (three of these were out-of-catchment area referrals).

Chapter IV

INTERNAL MONITORING

In order to assist staff in the care of patients, Manhattan Psychiatric Center has a number of committees designed to review various aspects of care and offer advice in the form of recommendations. Among these committees are: the Patient Care Committee, established to offer consultations to staff on patients who present unique treatment challenges; the Mortality Review Committee, designed to review the medical care rendered patients who have died at the facility; and the Special Review Committee which conducts investigations of untoward incidents -- including deaths, escapes, injuries, allegations of abuse and medically related incidents -- for the purpose of preventing the recurrence of such incidents.

The Commission's investigations into the care afforded the 60 deaths of MPC patients included a review of the operation of these committees, and considerable attention was focused on the functioning of the Special Review Commitee. Having the responsibility of investigating a broad range of incidents for the purpose of preventing their recurrence, this Committee can serve as an important vehicle for the internal monitoring of the facility's conditions.

The Commission's review, however, indicated that the Special Review Committee's operations were inadequate in a number of ways:

-- It failed to address incidents in a timely fashion. An indepth investigation into the sudden death of a young patient, involving serious medication issues, for example, was

not conducted by the Committee for 16 months. According to Committee members, the Committee was awaiting the receipt of the Medical Examiner's report;

-- As a result of delays, important aspects of cases were not considered and the deliberations and recommendations of the Committee were often more academic than practical; and

-- The Committee had no system to ensure the implementation of its recommendations.

As such, the Commission recommended that the operations of this Committee be reviewed and revamped to achieve a more timely review of incidents, a review of matters which relate more to practical than academic matters, and a system to ensure the communication and implementation of recommendations.

The Commission's ongoing review indicates that MPC has taken action on the Commission's recommendations.

Recent interviews with the Committee's Chairman and certain Committee members, as well as the review of meeting minutes from August and September of 1981, revealed that the streamlining of Committee membership and the addition of three clinical investigators has improved the Committee's operations.

With regard to the timeliness of deliberations, the review of Committee meeting minutes indicated that nearly 79% of the incidents reviewed by the Committee occurred within 30 days of the review -- a significant improvement. The review of meeting minutes also revealed that the deliberations of the Committee and its recommendations were less academic and more concrete and practical. For example,

the Committee's deliberations in a number of incidents led to recommendations for disciplinary actions of varying degrees against employees.

It was also found that the Committee has instituted a system for communicating and monitoring its recomendations. Recommendations are issued in writing to appropriate senior staff with requests for written statements of actions taken. These cases are then pended. Upon receipt of a written report on actions taken to implement its recommendation, the Committee reviews the actions to determine if they are satisfactory and, if so, closes the case with closing memoranda to the parties involved. Cases are not closed until the Committee is satisfied with the actions taken on its recommendations, and through the pending process, cases outstanding (i.e., no written report received, action on recommendations insufficient, etc.) are placed on all future agendas of Committee meetings until they are resolved.

In exploring the adequacy of this system, three cases in which the Committee made recommendations during its September 2, 1981 meeting were tracked by Commission staff. Staff found that in all three cases the actions recommended by the Committee were carried out. Within a week the Committee received written reports on the implementation of its recommendations, and at its next meeting (September 7, 1981) the Committee reviewed the actions and closed the cases with memoranda to the parties involved.

In summary, the Commission found the operations of MPC's Special Review Committee greatly improved in terms of timeliness of reviews, scope of reviews, and communication and follow-up of recommendations.

CONCLUSION AND RECOMMENDATION

On the basis of its extended review of conditions at Manhattan Psychiatric Center, it is the Commission's conclusion that in many respects patient care at the Center has improved. Acting on recommendations resulting from the Commission's initial review of 60 deaths, Manhattan Psychiatric Center has initiated changes leading toward such improvement. An Intensive Psychiatric Unit has been established to provide more intensive treatment of patients who pose dangers to themselves or others. More careful assessments of patients' secondary disabilities has resulted in more comprehensive treatment, directly or through referrals, for such patients. The enrichment of medical staff and the initiation of a communication network among staff and a liaison system with community hospitals has improved responsiveness to patients' medical problems. Initiatives in the area of discharge practices have facilitated the successful transition of certain patients into the community. The overhauling of the facility's Special Review Committee has improved its capability to serve as an effective vehicle for the internal monitoring of facility conditions.

The Commission's continuing review of conditions at the Center, however, indicates that in some respects the quality of patient care has been left unchanged or has seen little improvement over the course of recent years. The factors contributing to this situation are numerous. Certain initiatives of the Center, such as the creation of a DSS liaison system and case manager follow-up system, have not been broad enough in scope. Other initiatives, such as the comprehensive training of staff in emergency medical procedures, have met with little success, although not for a

lack of good faith effort on the part of the facility. Finally, in other areas, such as the definition of direct care staff roles and supervision, the Center has taken little initiative to act on Commission recommendations to improve patient care.

In sum, it is the Commission's conclusion that while patient care at Manhattan Psychiatric Center has improved, the Center must take additional action to both sustain its momentum of positive change and correct continuing deficiencies, in order to further enhance the care of its patients. Toward that end, the following are the Commission's recommendations.

General Treatment Issues

Acknowledging the improvement in care for patients who present particularly difficult treatment challenges and the attempts to better align resources to patient needs for the general population, it is recommended that:

1. Manhattan Psychiatric Center should assign top priority to the expressed need of Intensive Psychiatric Unit staff for refresher training in techniques for managing violent or assaultive patients.

(In response to the Commission recommendation, the Office of Mental Health reports Manhattan Psychiatric Center will implement such a training program.)

2. Manhattan Psychiatric Center should also assess the various approaches of its inpatient units to address the secondary disabilities of patients. While Center officials reported that such disabilities are most appropriately treated on an outpatient basis, it was

found that certain staff had initiated treatment on an inpatient basis. One unit has even arranged for a community based treatment facility to conduct treatment on the inpatient ward. The assessment of the various inpatient staff attempts at treating secondary disabilities can lead to:

(a) an identification and pooling of resources available for treatment;

(b) center-wide implementation of those more creative treatment approaches being implemented on specific wards;

(c) an augmentation or enrichment of on-ward programs; and

(d) more timely linkages to the community service network for those patients who will be discharged, to the extent that certain approaches incorporate community based services.

(In response to the Commission recommendation, the Office of Mental Health states:

> There are many practical limitations in implementing the system as described in the report. However, in the coming weeks, Manhattan Psychiatric Center will review the need for such a program to determine the efficacy and feasibility of implementing such a plan hospital-wide.)

3. To enhance the level of programming on the wards, Manhattan Psychiatric Center should review the role and supervision of direct care staff. This review should focus on possible strategies to increase direct care staff participation in programming, and supervision of such staff. Possible strategies to be considered should include:

(a) The assignment of therapy aides to specific patients, not only for such indirect patient care activities as "charting," but for participation in the more direct patient care activities, such as assisting activity specialists or rehabilitation specialists in conducting programming. The perception that therapy aides participate in programming on a "voluntary" basis must also be addressed.

(In response to the Commission recommendation, the Office of Mental Health reports:

This issue has been discussed among facility staff as well as with staff of the Commission. While it is recognized that the assignment of direct care staff to specific patients is one of several models that can be used to increase therapy aide participation in direct care activities, Manhattan Psychiatric Center feels that this model would not be suitable to the specific needs and problems of Manhattan Psychiatric Center as a whole. However, the facility has agreed to do a pilot project utilizing this model on the Murray Hill Unit. In addition, unit chiefs at Manhattan Psychiatric Center were directed to assign therapy aides to specific ward activities. this participation in programming is mandated and is not on a voluntary basis.)

(b) Consideration should also be given to the creation of a centralized pool of staff to engage in escort services. Nearly 22 percent of ward staff were engaged in this function at the time of Commission visits, thereby reducing staff available for on-ward activities. The creation of a centralized pool of staff for escort purposes may result in a

more effective utilization of the already limited resources and a lessening of disruptions of scheduled ward activities. Pool staff can escort a number of patients from different wards, and ward staff, scheduled to participate in programs, will not have to be deployed to escort patients.

(In response to the Commission recommendation, the Office of Mental Health asserts that this recommendation is not feasible, that "assignment of staff to a centralized pool to provide escort services would seriously deplete the number of staff available for patient care.")

4. While Commission staff noticed improved documentation of rationales for granting of home leaves and grounds privileges, as well as improvements in record keeping regarding restraint and seclusion practices, continuing deficiencies in both of these areas were noted. As such, both of these forms of treatment should be closely monitored by the Center's Quality Assurance Division to ensure that the treatments are appropriate and that, in the course of treatment, all applicable laws, regulations and policies are adhered to, including documentation requirements. Toward this end, it is recommended that individual instances of these treatments be reviewed periodically on a sample basis by the Quality Assurance Division. Reports of specific deficiencies noted should be sent to the units involved for appropriate action, and reports of the scope and nature of facility-wide deficiencies should be sent to the Center's administration for remediation through broad-based interventions, such as increased training and policy directives.

(In response, the Office of Mental Health indicates substantial agreement with the Commission recommendation.)

Medical Care

Although Commission staff noted a generally improved responsiveness to the medical needs of MPC patients, particularly when they complained of problems, the continuing deficiencies in routine medical practices, such as the lack of routine medical examinations, found by the Commission, as well as the continuing need to ensure staff proficiency in medical emergency procedures indicate that:

5. Manhattan Psychiatric Center must redouble its efforts to ensure that all patients receive mandated routine medical examinations, including not only the annual physical examination required for all patients, but also those specialized examinations required for certain patients on the basis of their age and sex. In attempting to ensure that all patients receive mandated medical services, MPC should involve and utilize its patient advocacy network by informing advocates of the nature and frequency of the services which are to be expected. Such advocates include not only the patient's family, but the Center's Board of Visitors and other Center-affiliated advocacy groups, as well as all direct care staff who, constituting the front line of the care delivery system, are in daily contact with the patient and his/her record of services.

(In response to the Commission recommendation, the Office of Mental Health states that efforts will be made to ensure that all required physical examinations are performed. The Office of Mental Health also asserts:

The Commission fails to note, however, the percentage of cases where patients refused to participate in these exams. From our experience, we know that the rate of refusal, especially in regards to gynecological examinations, is high. This observation has been corroborated by the most recent Periodic Medical Review report conducted by an independent consultation team. They reported that the 'facility appears to have a relatively high number of patients refusing required services.' This issue will be studied this year by the Program Evaluation Department.)

6. The Center should also revitalize its initiative to train all staff in emergency medical procedures, particularly those techniques dealing with cardiopulmonary resuscitation and obstructed airways. While some of the factors contributing to the failure of earlier attempts to train all staff were beyond MPC's control -- specifically, the resignations of the staff involved in the training program -- other factors contributing to the program's limited success, such as the failure rate of staff participating in the training program, must be assessed. It is therefore recommended that upon the recruitment of appropriate training staff, the Center initiate a review of earlier training activities for the purpose of identifying factors contributing to their failure. On the basis of this review, the Center should initiate a revised program of training designed to ensure that all staff are proficient in CPR and the Heimlich maneuver. It is also recommended that the Commission, the Regional Office and the facility's Board of Visitors receive copies of the findings of the facility's review of factors

contributing to the limitations of earlier initiatives in training, as well as copies of the training curriculum for the revised program of training in emergency medical procedures.

(In response the Office of Mental Health states it agrees with the substance of the Commission recommendation.)

Discharge Planning and Community Based Care

While Manhattan Psychiatric Center has attempted to establish a system of monitoring patients during the period of transition from inpatient to outpatient care, which has improved the linkages to outpatient services provided by MPC, the Commission's review indicates that MPC's initiatives are far too limited in scope and that patients referred to non-MPC aftercare services are still left to negotiate a complex community based care system without adequate support or follow-up. As such, it is recommended that:

7. Manhattan Psychiatric Center initiate a system to ensure that all discharged patients arrive at the residences to which they were discharged. The decision to actually accompany the patient to the residence should be based primarily on considerations of the patient's clinical condition and the proposed residential arrangement rather than the geographic location of the residence and public assistance status of the patient. At the time of discharge, the decision to ensure the patient's arrival at the planned residence by accompanying him/her or by following up in another fashion should be documented as well as the method, parties responsible and time frames for follow-up.

8. In addition to ensuring that patients are settled into the residential settings arranged prior to discharge, MPC must also ensure that plans for aftercare services are followed up. Toward this end it is recommended that:

(a) MPC adhere to Regional Office policies and ensure that all patients receive a scheduled appointment for outpatient services within five days of discharge.

(In response to the Commission recommendation, the Office of Mental Health indicates Manhattan Psychiatric Center will continue its efforts to ensure adherence to its Community Services policy provisions requiring inpatient social workers to contact the outpatient clinic to set up appointments for patients within five days of discharge.)

(b) MPC should also initiate a system to ensure that all patients actually keep their first clinic appointments. While efforts to follow up on patients who have failed to keep scheduled appointments may fall to outpatient staff of MPC or staff of clinics operated by other agencies, in the Commission's opinion it is incumbent upon MPC to monitor the implementation of discharge plans of all patients.

(In response to the Commission recommendation, the Office of Mental Health states that Manhattan Psychiatric Center will continue its efforts to ensure adherence to its Community Services policy provisions holding the facility responsible for ensuring comprehensive and continuous treatment between its inpatient and outpatient divisions.)

(c) In an effort to ensure a uniform system for follow-up of discharged patients, MPC must first address the differences among its own clinics with regard to patients who fail to keep scheduled appointments.

(In response to the Commission recommendation, the Office of Mental Health reports that Manhattan Psychiatric Center will continue its efforts to ensure adherence to its Community Services policy provisions providing for a uniform system of follow up, by case managers or community mental health nurses, of those patients who miss either their intake or ongoing clinic appointments. "In some instances, other clinical staff may be required to do outreach depending on the clinical nature of the specific case.")

(d) To the extent that non-MPC operated clinics are utilized as providers of outpatient services for individuals discharged from MPC, it is imperative that MPC negotiate with these clinics and establish a methodology for follow-up, with clear definitions of responsibility for patients who fail to keep their outpatient appointments. While MPC should take the initiative to establish a system for follow-up, it is recognized that the effectiveness of such a system is contingent upon the cooperation of a number of non-MPC operated clinics in the Metropolitan area. Therefore, it is further recommended that the Regional Office play an active role in the development and monitoring of a system for ensuring the follow-up of patients discharged from MPC.

(In response to the Commission recommendation, the Office of Mental Health indicates that:

...relationships with non-MPC operated clinics have been established and procedures have been set forth to ensure that these clinics accept OMH patients within five days and that appropriate follow up is done for those patients who miss their appointments.)

(e) Finally, the Commission recommends that outpatient clinics receive documentation regarding the medications supplied to patients upon discharge from MPC so that these medications, as well as the patient's overall clinical condition, may be taken into consideration in prescribing practices on an outpatient basis.

(In response to the Commission recommendation, the Office of Mental Health states that Manhattan Psychiatric Center will continue its efforts to ensure adherence to its Community Services policy provisions outlining "...the process whereby clnical information, e.g., medications prescribed, overall treatment plan, etc., is transmitted to the outpatient clinic.")

APPENDICES 1-3

Appendix 1

Table 1-A. Deaths by Type and Patient Status

Type	Inpatient	Outpatient
Total	48	12
Suicides	11	8
Death under unusual circumstances*	15	1
Death due to natural causes	22	3

*Excludes suicides.

Table 1-B. Inpatient Deaths by Type, Place or Status

Type	Total	Seclusion room	Ward	Infirmary	General hospital	Leave without consent	Home leave
Total	48	4	14	13	7	7	3
Suicides	11	1	1	0	0	6	3
Death under unusual circumstances*	15	3	8	0	3	1	0
Death due to natural causes	22	0	5	13	4	0	0

*Excludes suicides.

Appendix 1

Table 1-C. Outpatient Deaths by Type and Living Arrangement

Type	Total	Family care home	Single room occupancy hotel	With others in home or apartment
Total	12	4	7	1
Suicides	8	3	5	0
Death under unusual circumstances*	1	1	0	0
Death due to natural causes	3	0	2	1

*Excludes suicides.

Table 2. Distribution of Direct Care (Nursing and Therapy Aide) Staff by Unit at Time of Commission Site Visits

Unit	Number of wards	Number of patients on wards	Average therapy aides per ward	Average nursing staff per ward	Actual direct care staff/ patient ratio
CTU	7	273	4.71	0.78	.140
SRU	4	111	2.75	0.72	.125
ECU	3	82	2.33	1.00	.122

Table 3. Distribution and Percent Distribution of Patient Involvement in Program Activity by Unit at Time of Commission Site Visits

Unit	Total number of patients	On ward activity	Off ward activity	Grounds privileges	Community program	Other	No activity
CTU	273	65	34	10	9	8	147
SRU	111	15	16	9	3	0	68
ECU	82	34	4	12	0	0	32
			Percent distribution				
CTU	100	24.0	12.0	04.0	3.0	3.0	54
SRU	100	13.5	14.4	08.0	2.7	0	68
ECU	100	42.5	04.9	14.6	0	0	39

Appendix 4

Table 4. Distribution of Direct Care Staff Activities on Wards Visited at Time of Commission Site visits

Activity	Number of staff engaged in activity
Total	54
Lunch/break	4
Community meeting	2
Paper work	6
Suicide watch	4
Medications/ blood pressure	4
Escorting patients	12
Supervising patients in dayroom	12
Not engaged in any activity	4
Whereabouts unknown although "on duty"	6

*At the time of the Commission visits, there was a total of 363 patients present on the wards visited.