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*In the Matter of  
Joseph C.*

## A Resident of Craig Developmental Center

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A Report by the New York State  
Commission on Quality of Care  
for the Mentally Disabled  
and  
The Mental Hygiene  
Medical Review Board

August, 1980

CLARENCE J. SUNDRAM, *Chairman*

I. JOSEPH HARRIS  
MILDRED B. SHAPIRO, *Commissioners*





STATE OF NEW YORK  
COMMISSION ON QUALITY OF CARE  
FOR THE MENTALLY DISABLED  
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COMMISSIONERS

October 1, 1980

From: Clarence J. Sundram, Chairman

Subject: In the Matter of Joseph C.

Enclosed is an informational copy of the final report of the Commission and Mental Hygiene Medical Review Board investigation of the circumstances surrounding the death of Joseph C., a resident of Craig Developmental Center. The investigation by the Commission was undertaken as part of the Commission and Board's ongoing responsibility to review all deaths of mentally disabled persons.

The findings, conclusions and recommendations of the Commission report represent the unanimous opinion of the members of the Commission and the Mental Hygiene Medical Review Board. The report recommends that the developmental center take steps to ensure coordination and communication among medical staff charged with care of clients who are seriously ill. Specifically, the report recommends: that clients deemed ill enough to be sent to an emergency room should be promptly evaluated by a facility physician upon return; and, that facility nurses document decisions to deviate from established client treatment regimens. In addition, the report recommends that a transfer form be developed to include information, regarding the special needs of handicapped clients, for use whenever such clients are sent to other facilities or to outside practitioners, to increase communication between facility and community physicians. The report further recommends that the developmental center administration proceed, through education and direct intervention, to ensure that local general hospital physicians provide the same emergency care to developmental center clients as is afforded to the general public, and not misconstrue the developmental center's medical unit as comparable to a hospital's acute care surgical unit. Finally, the Commission report recommends that, following the unanticipated death of a client, there should be a forum for staff of all levels to exchange information, identify problem areas and plan for future intervention to prevent the recurrence of such deaths.

A draft copy of this report was shared with the Office of Mental Retardation and Developmental Disabilities and the Director of Craig Developmental Center. As indicated in the responses incorporated following the report recommendations, the Director of Craig Developmental Center has agreed to implement the recommendations we have made. The Director of the Craig Developmental Center and the Commissioner of the Office of Mental Retardation and Developmental Disabilities are required under the Mental Hygiene Law to report to this Commission within 90 days on the actions taken in response to our recommendations. The Commission will monitor such actions.

This report is being filed in accordance with Article 6 of the Public Officers Law and is considered a public document.

Enclosure

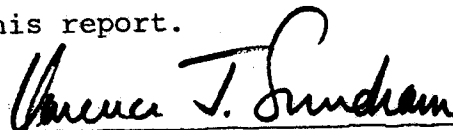


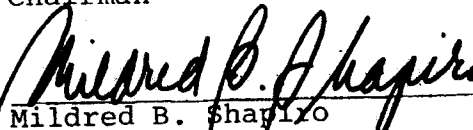
PREFACE

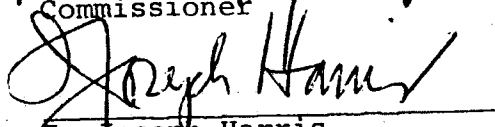
This investigation into the circumstances surrounding the death of Joseph C., a resident at Craig Developmental Center, was undertaken by the Commission and its panel of physicians, the Mental Hygiene Medical Review Board, as part of the Commission's and Board's ongoing responsibility to review all deaths of mentally disabled persons.

Findings, conclusions and recommendations set forth in the report represent the unanimous opinion of the members of the Commission and the Mental Hygiene Medical Review Board.

The contents of this report have been shared with the Commissioner of the State Office of Mental Retardation and Developmental Disabilities, the Associate Commissioner for the Western County Service Group, the Director of Craig Developmental Center, and the Board of Visitors of the developmental center. Statements of actions taken by Craig Developmental Center and the Office of Mental Retardation and Developmental Disabilities, in response to Commission recommendations, have been incorporated into the report following each of the recommendations. A copy of the response letter received from the Director of Craig Developmental Center is appended to this report.

  
Clarence J. Sundram  
Chairman

  
Mildred B. Shapiro  
Commissioner

  
I. Joseph Harris  
Commissioner



## INTRODUCTION

This investigation was initiated to determine the adequacy of the medical and nursing care and observation afforded this client and how such care may have impacted on his death.

## METHODOLOGY

The investigation consisted of several visits to Craig Developmental Center by Commission staff, interviews with Craig physicians, nurses, Deputy Director Clinical, and a Dansville surgeon, lab technician and others. In addition, the clinical record was reviewed as well as the Noyes Hospital record, and the Rochester Psychiatric Center record.

## BACKGROUND

Mr. C., a 38-year old resident at Craig Developmental Center (CDC), had been institutionalized since age five. He was diagnosed as Downs Syndrome, severely retarded, but was verbal and cooperative and participated in unit activities. His medical history included hepatitis in 1964 while a resident at Willowbrook State School (now the Staten Island Developmental Center).

## CIRCUMSTANCES OF DEATH

On November 2, 1978, in accordance with an agreement between Craig Developmental Center and Rochester Psychiatric Center (RPC), Mr. C. was transferred to the medical unit at RPC "for further diagnostic workup and treatment of jaundice and cellulitis of

him down." She said restraint orders were not necessary as they had to "protect the tubes" and said it was not the policy at Peterson to secure physician orders for such restraints. The nurse recalled phoning the OD in order to get sedation for Mr. C. who was causing a noisy commotion as 1:00 a.m. approached. According to the record, the OD ordered Meperedine 50 mg. IM which the RN administered. Soon after, the LPN, informed the RN that the client had pulled the IV out despite the restraints. Fifteen minutes later he pulled the NG tube out. The RN could not recall if she called the OD to notify him about the IV and NG. The OD could not recall if he had been notified. The RN wrote on the doctor's order sheet, as a verbal order from the OD:

" 50 mg. Meperedine IM stat; listed another liter of IV fluid to follow the present one "to run until a.m." and "the NG tube to low Gomco (suction machine) until a.m."

Other than the Meperedine, she could not recall if the OD actually gave the orders saying it was standard to attach an NG tube to a Gomco suction machine and to keep an intravenous line open. The OD said he ordered the NG and IV. It is CDC policy that nurses restart IV's and reinsert NG's but the RN offered the following, at different times, as her reasons for not reinstating these measures, which had just been initiated by the surgeon some two hours earlier in the emergency room:

- (1) The client "needed the rest -- so we took off the restraints and let him sleep."
- (2) The doctor, "wasn't that concerned about Joe -- he didn't come to see him; just said it'll wait until morning."



- (3) The fact that the LPN (who knew Mr. C. from an earlier admission) told me that "he had been in RPC and was very sick and all that could be done for him was to keep him comfortable."

2:00 a.m. The LPN recorded "Sleeping at this time. Apparently comfortable, sleeping rest of night."

6:00 a.m. This next note was written four hours after the last note. The LPN noted: "Awake ... c/o abdominal pain, temperature 101.2, pulse 100, respiration 30." Ms. L. said they did not call the physician at this point in her shift as "we knew they'd be coming around soon -- unless it was a weekend and then some of them are hard to get."

9:00 a.m. The living unit physician saw Mr. C. at this time, as his tour of duty began approximately 8:00 a.m. on this Saturday morning, and he was to function as OD for the facility. He relieved the outgoing OD, who is not recorded as having gone to Peterson to check on the client either during the night or early morning. The living unit physician, who knew Mr. C. well, expressed surprise at seeing him in the medical unit. He noted in the record:

"While I went on hospital rounds, I examined him and found him in a semi-comatose condition, very restless and very agitated ... cyanotic ... dark stool mixed with fresh blood ... I notified the director of his critical physical condition which needed immediate hospitalization, better facility and for better workup. The director advised me to contact the surgeon and the medical consultant in Dansville."

The living unit physician attempted to contact the surgeon and did contact the medical consultant. He also called the physician at RPC regarding transferring the client back there. This RPC physician

said he told the doctor to "get the client to the nearest hospital immediately." The living unit physician stated that the ambulance was called but it is a slow process sometimes, as drivers and a nurse must be recruited. It is particularly a problem on weekends, he said. The time of call for an ambulance is not recorded.

10:35 a.m. The living unit physician noted that Mr. C. died. His note states:

" ... while I was preparing to transfer at 10:10 a.m., this patient's condition deteriorated and I immediately restarted an IV fluid ... and reintroduced the NG tube fitted with the suction machine and administered oxygen."

The autopsy report lists pathological findings as:

- (1) • Acute generalized peritonitis;
- (2) due to perforated small duodenal ulcer;
- (3) hepato-renal failure;
- (4) due to active chronic viral hepatitis;
- (5) post-necrotic cirrhosis of the liver with foci of recent cirrhosis;
- (6) mental retardation.

#### FINDINGS

(1) THERE IS A CONFLICT BETWEEN THE ACCOUNTS OF THE EMERGENCY ROOM SURGEON AND THE CDC PHYSICIAN CONCERNING BOTH THE INTERPRETATION OF THE X-RAYS AND WHETHER THE CORRECT X-RAYS WERE SENT WITH THE CLIENT.

According to the OD, he read the x-rays and there was "free air above the diaphragm indicative of a ruptured viscera." The official report on the reading of the x-ray was done by a Dansville radiologist after the death. The

date of this report is not specified but it does not note free air. (see attachment)

The surgeon stated that the x-ray he read at the emergency room did not show free air and stated he believes he may have been shown the wrong x-ray. His belief is based on the knowledge that CDC uses an old-type wet x-ray and the x-ray he saw was dry. This type of x-ray requires, according to the x-ray technician, four minutes to develop, eight minutes to fix, 1/2 hour to wash and 3/4 to 1 hour in the dryer. This totals anywhere from 1 hour and 27 minutes through 1 hour and 42 minutes. Thus, they could not have been completely dry between the time they were ordered on admission to Peterson (approximately 9:00 p.m.) and transfer to Noyes (10:00 p.m.).

(2) THERE IS A CONFLICT BETWEEN THE ACCOUNTS OF THE EMERGENCY ROOM SURGEON AND THE CDC PHYSICIAN CONCERNING WHETHER THE SURGEON WAS APPRISED OF THE FACT THAT THE CLIENT WAS ON PREDNISONE THERAPY.

The surgeon stated that, had he known the patient was on Prednisone, it would have had an effect on his evaluation.

The nurse accompanying Mr. C. had no knowledge of the patient to relay to the doctor and there is conflict as to what records accompanied the client. All parties agreed that a consent for surgery form signed by the CDC director, was sent. However, the OD, claiming he notified the surgeon of the Prednisone via a note on a transfer form (see attached), stated he believed this form accompanied the client. The surgeon denies this was sent and the form does not contain a section where the surgeon would enter a note. This transfer form is one made out by the OD upon his transfer of the client from his regular unit to Peterson. Nurses inter-

viewed stated it is not CDC's policy to send this form to Noyes. The surgeon noted that local nursing homes use transfer forms to relay information to hospital physicians but that CDC does not use a form.

(3) THE CLIENT WAS RETURNED TO CDC FROM THE NOYES HOSPITAL EMERGENCY ROOM PREMATURELY PRIMARILY DUE TO THE FACT THAT HE WAS A CRAIG RESIDENT.

The surgeon stated that had Mr. C. been living in the community, he would have admitted him for observation but he felt returning the client to CDC would assure monitoring throughout the night. However, a person exhibiting the same signs as did Joseph, who was not a CDC client, would not have been sent home but would have been admitted to Noyes for observation.

(4) THERE IS A CONFLICT BETWEEN THE ACCOUNTS OF THE EMERGENCY ROOM SURGEON AND THE CDC PHYSICIAN CONCERNING INTERPRETATION OF THE SURGEON'S ACTION IN DISCHARGING THE CLIENT BACK TO THE FACILITY.

The surgeon noted that a possible diagnosis of cholecystitis or gastroenteritis was documented with question marks to indicate a definite diagnosis had not been made. He further noted that he kept the client in the emergency room for nearly two hours, observing and hydrating him with intravenous fluid and introduced a nasogastric drainage tube. He stated that the presence of these should have been clear indicators to CDC staff that the client required further care and monitoring although he did not document this on the ER record. The OD stated that he felt the discharge from the ER meant Joseph was not seriously ill. Therefore, he did not go to Peterson to see the patient after he returned from Noyes.

(5) THE CONFLICTING INTERPRETATIONS OF THE SURGEON'S ASSESSMENT OF THE CLIENT AND THE BREAKDOWN IN COMMUNICATION RESULTED IN THE PROVISION OF LESS THAN OPTIMAL MEDICAL CARE.

The OD, prior to sending the client to the ER, was quite sure of his diagnosis, which ultimately proved to be correct. He stated, when the surgeon called him and said it was not an acute abdomen, he believed he had erred in his own judgment.

The OD, who some four hours before had made a diagnosis of acute abdomen and who did not know Joseph before the previous evening, gave a telephone order of Meperidine 50 mg. IM stat in response to the nurse's request. He did not go to see the client despite being told of his noisy uncontrollable behavior, and, he accepted the surgeon's sending the client back to Peterson as an indicator that his own previous diagnosis was in error. The physician also failed to order any monitoring or vital signs on this client, because he assumed the surgeon had cleared the patient of any serious problem.

The administration of this medication had the effect of masking the symptoms of the patient's condition and thus inhibited monitoring of the patient. The surgeon stated that his diagnosis was clearly still under question and that IV and NG tubes were necessary facets to the monitoring and maintaining of the patient. He expected that CDC would continue to monitor the patient upon his return to Craig.

After his discharge from the ER, Mr. C. was next seen by a physician at 9:00 a.m. The living unit physician was just coming on-duty at that time and was making rounds. When the living unit physician saw Joseph, he immediately

assessed his condition as "serious" and in need of transfer; however, this was never accomplished. The hour and a half that transpired between the 9:00 a.m. assessment by the physician and the client's death at 10:35 a.m. was filled with phone calls from the physician to the director who instructed him to call the surgeon and medical consultant in Dansville, which he did. He further called the physician in Rochester and called for the CDC ambulance. The time of this call cannot be ascertained, as CDC does not log such calls. The physician also reinstated the IV and NG tube during this period. These tubes had not been reinserted for the past eight hours since the client removed them.

(6) THERE WAS A BREAKDOWN IN THE QUALITY OF MONITORING AND NURSING CARE DUE TO MISINTERPRETATIONS AND POOR COMMUNICATION, AS WELL AS TO NON-ADHERENCE TO USUAL POLICY.

The receiving night shift head nurse at Peterson did not know the client. The LPN had known of Joseph from a past stay at Peterson and apparently misinformed the head nurse that he was suffering from some incurable disease.

Joseph was noisy and uncooperative when he was returned to CDC, and staff had to tie him, hands and feet, in order to keep him still in an effort to prevent him from pulling out his intravenous line and NG tube.

When Mr. C. removed his IV and NG tubes, they were not reinserted. His vital signs were not recorded during the nighttime hours of 1:00 - 6:00 a.m., not only because they were not ordered by the physician but also because the nurses stated they interpreted his transfer back from Noyes and the OD's subsequent non-involvement (not seeing the patient) as indicators that all was well.

(7) THERE WAS AN ERROR IN PRESCRIBING OF MEDICATION WHEN THE CLIENT WAS TRANSFERRED FROM ROCHESTER PSYCHIATRIC CENTER TO CRAIG DEVELOPMENTAL CENTER.

When questioned individually about the double dose of Prednisone and the dropping of the Aldactone upon return of the client to CDC, the RPC physician stated he had no explanation as to why the CDC physician ordered the double dose and defended his use of the abbreviation QOD, which a CDC physician had pointed out as confusing. The RPC physician further said he felt the Aldactone would enhance the action of the Lasix and did not agree with its being discontinued by the CDC physician. He stated that the Lasix would not be as effective in cirrhotic patients without the addition of Aldactone. As to the use of Prednisone, the RPC physician agreed that most jaundice, other than the obstructive type, "cures itself" with time, rest and diet but "we use Cortisone when, there is no progress without it." He stated the plan was to slowly taper Mr. C. off the Prednisone and indeed this was noted in RPC records. Although this plan was not transmitted to CDC, the RPC physician said "any doctor should know to wean a patient slowly from the drug and that, in cases of hepatitis, it should be withdrawn as the patient improved." He also stated CDC physicians could have called him if they wished information.

The Peterson Unit physician at CDC stated that he realized he had inadvertently ordered twice the dose of Prednisone by ordering it daily rather than every other day. He had been made aware of this by CDC Administration after Mr. C.'s death. He admitted to knowing the dose should be weaned slowly as the client improved and further agreed Mr. C. had, in fact, improved as he had been transferred from the medical unit back to his former building. He noted that after the transfer back to his living unit, he was no longer

in charge of the client's medical regimen. He did not have any rationale for omitting the Aldactone.

(8) THERE IS NO EVIDENCE OF A COMPREHENSIVE INVESTIGATION INTO MATTERS CONCERNING THIS CLIENT'S CARE BY THE FACILITY.

The facility director, after his death, assigned the task of inquiring into the incident to a top-level clinician. The DDC submitted 1 1/4 page report to the director indicating there had been no negligence.

It is noteworthy that, in his memo of May 4, 1979 to the director of CDC regarding the inquiry into this death, the DDC noted the resident was getting 40 mg. Prednisone daily but did not note that this was done in error and, in fact, appeared to have rationalized its use. Nonetheless, Joseph received a daily double dose of this drug for two weeks prior to his death. The memo reads:

"as prescribed and advised at RPC and after his transfer to CDC, Dr. ... after consultation with RPC, changed to 40 mg. once a day with no untoward effects for two weeks before the acute illness began."

However, the RPC physician denied he ever told the CDC physician to "double the dose" -- especially since the client was improving. The CDC physician also denied receiving such instructions, which makes the DDC's explanation more puzzling.

The report appeared to be essentially a gathering of data from the record and the opinion of the author concerning the case. There are no statements by staff involved and, during the course of the Commission's investigation, many employees interviewed stated they were never apprised of the problems or issues in this case. There was no meeting concerning the death among medical staff involved or other



staff in an effort to look into the incident and draw up recommendations to prevent similar occurrences.

### CONCLUSIONS

(1) Joseph C. did not receive the care and attention he needed largely due to the fact that the physicians charged with his care did not adequately communicate with one another. This lack of communication is evidenced by:

- (a) The change in one medication dosage and elimination of a second medication upon transfer from RPC to CDC;
- (b) The plan to taper off the Prednisone was not explicitly communicated and CDC physicians were not aware of this plan;
- (c) Adequate information about the client's medication was not conveyed to Noyes physicians by CDC when Mr. C. was seen in the emergency room;
- (d) When Mr. C. returned from Noyes to CDC, there was inadequate communication between physicians concerning his condition and the need for monitoring.

(2) The care rendered this client was suboptimal; supporting this conclusion are the following facts:

- (a) Despite the diagnosis of acute abdomen, and IV or NG tube was not initiated prior to transfer to the Noyes emergency room;
- (b) The client was returned to CDC after two hours in the emergency room whereas a non-institutionalized patient would have been retained for observation at the hospital;
- (c) CDC staff did not attempt to reinstitute the IV and NG when removed by the client;

- (d) The client was found to be in acute distress at 9:00 a.m. by the physician. Nursing staff had assessed him as in pain some three hours before but had not alerted the physician;
- (e) When the physician found the patient to be seriously ill at 9:00 a.m., there was a delay of some 1 1/2 hours during which phone calls were made to other physicians and there was an attempt to secure an ambulance.

(3) The issue of the x-ray remains speculative. Since the Noyes emergency room records the client as arriving at 10:35 p.m., he must have left CDC by 10:15 p.m. Given the lengthy processing of the x-rays, it is difficult to state they could have been dry enough to be put in a paper envelope by 10:15 p.m. However, it is possible that proper x-rays were sent and read and that the OD physician's correct diagnosis was not so much a product of reading the x-ray but of assessment of other symptoms.

(4) While the surgeon obviously erred in his diagnosis, his conservative approach to surgery, given the findings, cannot be faulted. His discharge of the client back to CDC, however, is questionable. Because Joseph was a resident of a developmental center, he was not afforded the usual and routine observation of his abdominal condition by staff at a general hospital. This was denied him due to the surgeon's belief, that the nursing and medical staff at CDC's Peterson Unit would perform the necessary observation and assessments on Joseph during the night as well as the prevailing belief that Peterson Unit is somehow synonymous with an acute care hospital. CDC did not monitor this client's care in the manner in which it would have been done in an acute hospital setting. In fact, the client was virtually unattended from 1:00 to 6:00 a.m. and was found at 6:00 a.m. to be in pain with elevated vital signs but still was not seen by a physician for another three hours.

(5) When the OD learned that surgery was not going to be performed, he apparently immediately acquiesced to the surgeon's decision and diagnosis. A physician with many years of experience, the OD, nonetheless, did not question the surgeon despite his earlier diagnosis. We believe that it would have been advisable for him to visit this client or communicate with the surgeon after his transfer back to Peterson. The client's care was adversely affected by not ordering that vital signs be monitored, and by giving a telephone order for an analgesic in an undiagnosed patient which proceeded to mask the symptoms over the nighttime hours. However, he treated the client in this manner due to the fact that the surgeon had not communicated the need to monitor this patient throughout the night.

(6) This client did not receive the usual and acceptable nursing observations during the nighttime hours. This appears to be due primarily to lack of adequate communication. The nursing staff apparently interpreted the surgeon's release of the patient from the emergency room, as an indication that the client was not very ill. This belief was reinforced by the CDC physician who did not visit the patient and ordered an analgesic injection over the phone. Further, the RN interpreted the misinformation given her by the LPN that Joseph was in some terminal state as a reason to ignore physician orders.

(7) The lack of adherence to the medical orders constitutes poor nursing practice. Intravenous needles and tubings and nasogastric tubes are often removed by disoriented patients, very young and very old patients, and patients in pain, and often become dislodged for other reasons. It is the nurse's responsibility to assure such treatment is reinstated. This is all the more important and striking in this case, as the treatment had only been in progress some two hours when it was discontinued by the client. In cases where the nurse makes a decision to depart from prescribed treatment, there should be strong justification, as well as documen-

tation as to the reasoning behind this decision. CDC nurse administrators interviewed stated that the nursing staff's actions in this instance were not indicative of CDC nursing policy. The variety of reasons for allowing this to occur given by the nurse appears to indicate her realization that this was a departure from accepted practice.

(8) It is speculative whether Joseph would have survived this surgical emergency had the ulcer perforated and exhibited its painful symptoms at a more opportune time. A combination of factors including poor communication and nighttime hours contributed to the breakdown in care of this client.

(9) The issue of the double dose of Prednisone being administered by order of the CDC physician appears to represent human error in translating the discharge summary from RPC. The RPC physician wrote the dose to be given "q.o.d." (every other day) and this was either misread or misinterpreted at CDC to "q.d." (every day). It also represents lack of knowledge of Cortisone therapy on the part of the CDC physician, in that there was no tapering off or plan to taper off the dose. This is especially serious since Joseph was improving and had been transferred from the medical unit to his own living unit. Despite the RPC physician's assertion that all physicians should know that Prednisone should be slowly weaned from a stabilized patient, neither the medical unit physician at CDC, or the living unit physician, documented or indicated when interviewed that they had such a plan. The plan, if any, was merely to renew the orders as needed. The lack of ordering Aldactone as an adjunct to the Lasix appears to be a result of an oversight by the CDC physician, who was not apprised by the RPC physician of the beneficial effects of combining these drugs in a client with this diagnosis.

RECOMMENDATIONS

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

(In response to the Commission recommendation, the director of Craig Developmental Center indicates that facility physicians have been reminded, through a policy memorandum, that an immediate examination and reevaluation are required for all patients returned from outside hospital care or from emergency room visits. The utilization review nurse/coordinator, who is responsible to the facility director, has been assigned responsibility for monitoring compliance with this policy).

(2) CDC nurses should be counseled as to their responsibilities for maintaining established treatment for clients. Any decision to deviate from this treatment should be documented clearly by the nurse. Such documentation should include the rationale for any departure, if prior consultation with a physician has not been possible.

(In response to the Commission recommendation, the director of Craig Developmental Center reports that recently a nursing coordinator has been appointed and that a reassessment of nursing practices and procedures has been initiated, to include study and revision of such issues as: maintenance of established treatment; adherence to medical orders; follow-up procedures and communication between staff members).

(3) OMRDD should evaluate the practice of sending clients to medical units of psychiatric centers for medical work-up rather than to community general hospitals. The desirability of having

a retarded individual spend a prolonged period of time residing in a psychiatric facility for supposed purposes of obtaining medical care not otherwise available at the developmental center should be explored.

(The State Office of Mental Retardation and Developmental Disabilities indicates that utilization of psychiatric centers for medical workups on developmental center clients has been discontinued since the reorganization of the Department of Mental Hygiene).

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

(The director of Craig Developmental Center reports, in response to the Commission's recommendation, that forms for transfer and admission have been revised following a joint study by the medical and administrative officers of Noyes Memorial Hospital and the developmental center. The forms include both information required by a general hospital as well as information addressing the special needs of severely handicapped persons).

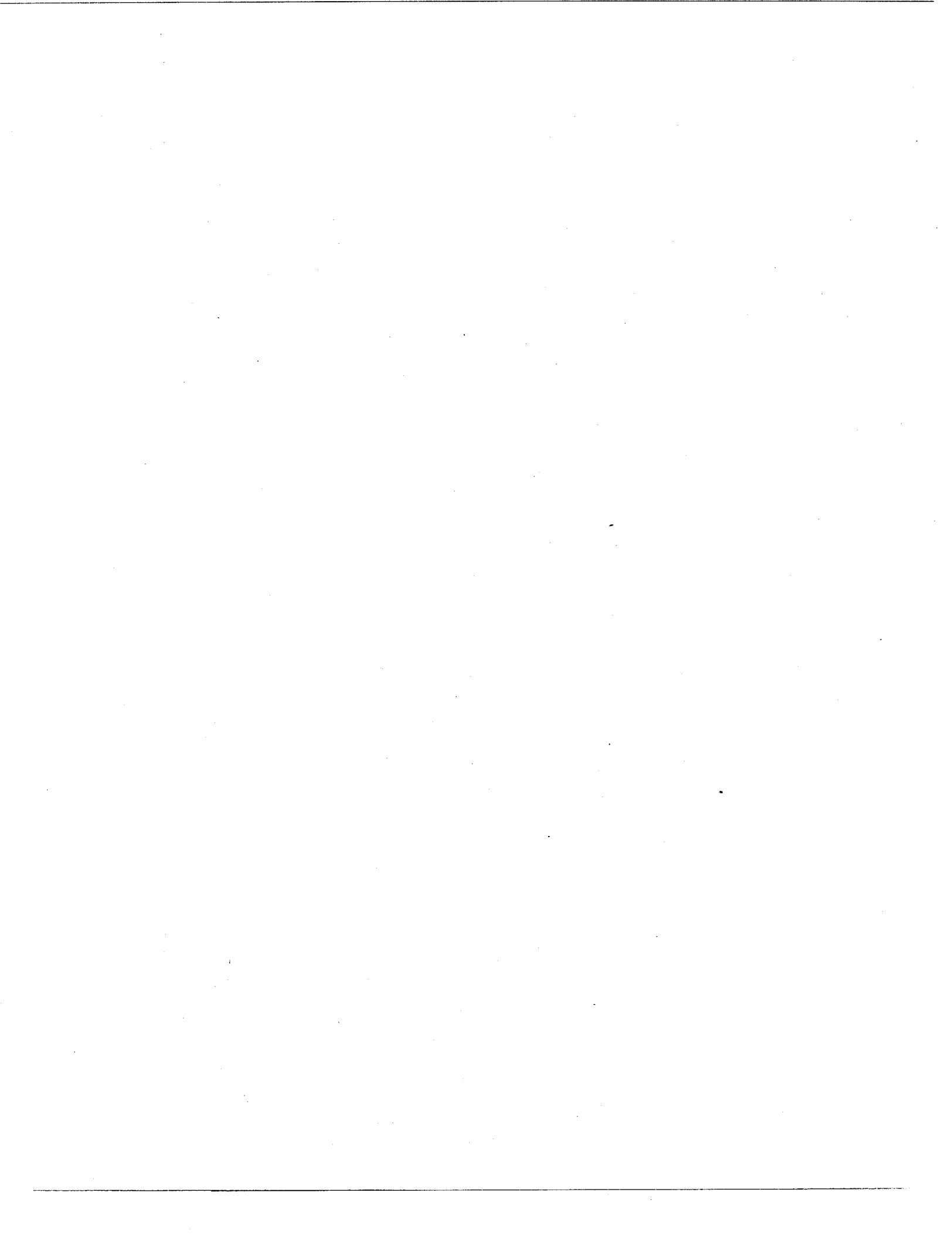
(5) CDC Administration should proceed, through education and intervention, to ensure that Noyes Hospital physicians provide the same emergency room care to CDC clients as is afforded the general public. CDC clients should not receive lesser care and attention simply because the institution has a medical unit. Further, this "medical unit" should not be misconstrued as comparable to an acute care hospital surgical unit. In this regard, it is CDC's responsibility to ensure that community practitioners and consultants view the CDC medical unit as an infirmary and convalescent type unit and not as a substitute for

the care and treatment afforded in a hospital setting where staff are dealing on a daily basis with pre- and post-operative patients.

(In response to this Commission recommendation, the State Office of Mental Retardation and Developmental Disabilities indicates that conferences have been held between Noyes Hospital and CDC staff to provide education and support in the delivery of care to CDC clients in the Noyes emergency room and inpatient areas. The director of CDC indicates that CDC clients are now being admitted or retained at Noyes Hospital on the same basis as other patients).

(6) Following a death of a client wherein the demise was not anticipated, after an initial thorough investigation, there should be a process for all staff involved, at all levels, to exchange information, identify problem areas and to plan for future intervention to prevent their reoccurrence.

(The director of CDC reports, in response to this Commission recommendation, that a special clinical pathological conference for medical and nursing staff was scheduled to consider the implications of the Commission study and any additional appropriate corrective measures. Future unusual deaths will be reviewed by the facility's mortality committee, which is chaired by the facility pathologist and will include the coroner when appropriate).





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APPENDIX

July 8, 1980

5. The Peterson building at Craig Developmental Center was a functioning hospital until 1977 when the operating room was closed and all surgery was sent to community general hospitals. Noyes Memorial Hospital being the most readily accessible has cared for most patients. Since closure of the Peterson OR, some of the nursing staff has changed and presently assigned nurses are not as experienced in post-operative care as before. This has been discussed with the Chief of Staff at Noyes Memorial and since April has been considered as a factor in the return of patients to Craig. Patients are now being admitted or retained on the same basis as any other patient.
6. Unusual deaths are reviewed by the mortality committee under the chairmanship of the pathologist and including the coroner should the situation warrant. In this instance in addition, a C.P.C. for medical and nursing staff has been arranged for July 22, 1980, when the many implications from this study will be considered and additional corrective measures considered.

Thank you for sharing this draft report with me. Your findings will provide me with abundant material for staff education and I trust that these discussions will assist us in providing a better quality of care to our clients.

Very truly yours,



Nadene D. Hunter, M.D.  
Director

NDH/O

cc: Commissioner James E. Introne  
Mr. Richard Merges  
Dr. Judith Rettig





