

Misc. publication 07

Observations and Comments

BASED ON A SURVEY

of

CALIFORNIA STATE MENTAL FACILITIES

by the

CALIFORNIA MEDICAL ASSOCIATION



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Submitted to the California State Department of Mental Hygiene

January 18, 1965

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Part II

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INTRODUCTION

The survey which is being reported herewith has been carried out by the California Medical Association at the request of the California State Department of Mental Hygiene and the Senate Committee on Business and Professions.

The directives for the survey are contained in Senate Resolution No. 131:

RESOLVED BY THE SENATE OF THE STATE OF CALIFORNIA, That the Department of Mental Hygiene is urged to request the California Medical Association, acting through its appropriate committees and associated specialty organizations, to undertake a comprehensive survey of state mental institutions, including care of patients, quality and adequacy of personnel and adequacy of facilities; the California Medical Association to be further requested to submit to the department a full written report of its findings, conclusions and recommendations; and be it further

RESOLVED, The Department transmit such a report, together with its comments, to the Senate Committee on Business and Professions.

During May, 1963, a pilot survey of five hospitals was made by five teams of physicians. A preliminary report, based on their visits, was submitted to the Department of Mental Hygiene on June 10, 1963. A copy of that preliminary report is appended to this document. In it will be found a discussion of objectives and methodology, to which the reader's attention is directed.

Since the completion of the preliminary report, teams of physicians have visited the remaining nine hospitals within the State system, as well as day treatment centers. The reports of these teams are included as an integral part of this document. It will be noted that there is considerable variation among these individual reports, in terms of professional point of view, orientation, and emphasis. Since the physicians who were invited to serve on the survey teams represent a broad cross-section of the medical community in California, embodying a number of specialties, a range of experience, and a variety of points of view, we felt that we could most satisfactorily reflect their findings by not imposing a rigid form upon their method of reporting.

In the following section of this report is a discussion of certain observations which are applicable to the entire State mental hospital system. Rather than present them as formal findings and conclusions, we offer them as impressions garnered by well-qualified observers. More detailed comment on the individual hospitals and specific recommendations relevant to each of them are contained in the separate hospital reports.

OBSERVATIONS AND COMMENTS

Treatment Program

The hospital staffs have a very limited number of psychiatrists in proportion to the patient population, and a majority of those psychiatrists are committed to administrative responsibilities, rather than to diagnosis and treatment of patients. Accordingly, individual psychotherapy constitutes a relatively small segment of the treatment program. In many instances, psychotherapy is administered not by a psychiatrist but by a psychologist or a psychiatric social worker. Although the qualification of members of these professions to assume treatment responsibility is not questioned, closer psychiatric supervision is suggested.

Treatment programs generally seem to be at their best in receiving units and units housing patients for intensive short-term care. It was observed, however, that initial psychiatric appraisal of newly admitted patients is sometimes deferred unduly (principally because of shortage of personnel), and it is urged that an initial contact between a psychiatrist and the patient, as well as a member of his family, be made within hours after admission. Patients who are so disturbed that they require medication should be seen immediately.

In lieu of individual psychotherapy, all hospitals rely heavily on group therapy. The designation "group therapy" is somewhat loosely applied. Sometimes it is conducted under the direction of a psychiatrist, a psychologist, or a psychiatric social worker, any one of which can be assumed to understand the underlying dynamics of the therapeutic process. In other instances, the treatment sessions may be under the direction of the ward physician (who is not a psychiatrist), a nurse, or a psychiatric technician. It is suggested that all persons responsible for group psychotherapy receive adequate psychiatric orientation, and that all such treatment programs be re-assessed to make sure they are directed toward advancing the patient's self-awareness, rather than merely providing an outlet for exchange of opinions and feelings.

In some hospitals, an inordinate amount of patient inactivity was observed, and it is suggested that programs of adjunctive therapy (occupational therapy, industrial therapy, recreation therapy, etc.) be intensified.

Chemotherapy figures importantly in the treatment for all categories of patients. Budgetary considerations and procedural rigidity seriously imperil this form of treatment. In some hospitals, an adequate supply of drugs depends on the largesse of pharmaceutical firms who make their products available on a time-limited basis for research. In other cases, hospital pharmacies exhaust their supply of the more commonly prescribed drugs before the allotted budgetary period, and it is necessary to substitute other medication. Insufficient supply of drugs for patients in after-care programs sometimes necessitates the rehospitalization of patients. It was the consensus

of the survey teams that it was false economy to limit the supply of drugs which can accelerate the patient's discharge from the hospital and support him during his period of rehabilitation.

Electroconvulsive therapy was used conservatively in most hospitals, and was selected as the treatment of choice only when it was clearly indicated. Not all hospitals, however, were consistent in their practices with respect to proper premedication of patients, nor was resuscitation equipment uniformly available for emergency use.

It was the observation of the visiting physicians that neither restraints nor seclusion was excessively used, but it is recommended that when these are used, they should never be prescribed on a PRN basis. Orders for treatment of this type should be reviewed by a physician every 24 hours.

Up-Grading the Professional Climate

A number of limiting factors were noted which adversely affect the morale of the professional staff and/or the quality of professional services.

The difficulties of recruiting physicians (both psychiatric and non-psychiatric) to staff positions must be acknowledged. Among the factors which contribute to this are: salaries below earnings attainable in private practice; reluctance to be affiliated with a circumscribed medical community in which professional stagnation becomes a threat; disinclination of many physicians to become part of an apparatus in which individual professional judgment must be waived in the interests of over-all institutional policy or of organizational hierarchy; the debilitating effects, professionally, of working in a setting in which the high proportion of chronically ill patients tends to orient a hospital toward custodial care rather than treatment.

The ward physician, who has responsibility for the treatment program, often has little psychiatric orientation and is provided few opportunities to strengthen his capacities through postgraduate training or consultation. Treatment leadership is often assumed by psychologists and psychiatric social workers, with ward physicians, although nominally in charge, shunted into a passive and somewhat submissive role. Every effort should be made to improve the liaison between staff psychiatrists and ward physicians and to stimulate the ward physician to greater understanding of psychiatric concepts.

Most hospitals could advantageously use more physicians from the surrounding community as consultants and could make better use of the consultants who are nominally affiliated with them. These consultants should be utilized not only for the teaching of residents and for continuing medical education of staff but also in case consultation with ward physicians and with members of the medical and surgical staffs.

Most hospitals are organized with respect to staff committees in conformity with the requirements of the Joint Commission on Accreditation

of Hospitals, but in many instances committee meetings are perfunctory and the potential they could afford for professional education is neglected.

Better relationship and more fruitful interchange between members of hospital staffs and their local county medical societies is suggested. A program directed toward these ends, jointly undertaken by the California Medical Association and the Department of Mental Hygiene, is suggested.

The educational programs provided members of the medical staffs should be encouraged to participate in postgraduate medical education programs away from the hospital site, and their attendance should be made feasible in terms of time off from hospital duty and financial reimbursement for travel expenses.

Strengthening research programs within the hospitals would tend to upgrade the professional climate. It was observed that a wealth of clinical material was being wasted because of the limited emphasis on research. In augmenting research activities, care must be taken that new psychiatric personnel recruited to the hospital is not all diverted to research. It is also important that close liaison be maintained between treatment personnel and research staff so that they can mutually enrich each other's professional insights.

Consideration should be given to the appointment of a medical advisory committee for each of the state hospitals. The committee would be appointed by the California Medical Association; would be made up of representative physicians from the nearby community; would have as its prime mission working with the hospital staff to help create and sustain a dynamic and forward-moving professional climate.

Utilization of Professional Personnel

All hospitals could fulfill their responsibilities for patient treatment and care more readily if there were expansion of professional staff in all categories (particularly psychiatrists, psychologists, social workers and psychiatric technicians). Recognizing that this goal can be achieved only in a limited way, consideration should be given to better utilization of existing staff.

The proper dissemination of the specialized skills of the psychiatrists, not only for diagnosis and treatment but for supervision of other staff persons with treatment responsibilities, is central to this recommendation.

Although it may be unavoidable that a high proportion of staff psychiatrists are pre-empted for administrative positions, it is suggested that all psychiatrists in administrative posts, including the hospital superintendent keep reasonably informed concerning the hospital's patients, the treatment programs provided them, and their response to treatments. Concerning hospital superintendents, it might be remembered that for each hospital, the man who holds this post has a dual function: not only must he maintain liaison with the community and with the Department of Mental Hygiene in his role of superintendent; he must fulfill responsibility to the hospital's professional staff and its patients, in his role as medical director.

The impressive burden assumed by psychiatric technicians in direct patient care is recognized; this is particularly noteworthy with respect to patients who are chronically ill and those who are mentally retarded. Every effort should be made to sustain the high morale of this group; this includes neutralizing, giving what sometimes seems to be an incipient rivalry for status between registered nurses and technicians. To this end, we do not feel that it is necessary for an RN arbitrarily to be placed in charge of each ward. On the other hand, it is desirable to make the best possible use of the specialized training of the RN's. Accordingly we propose that in ward organization structure, the RN serve as a link between the ward physician and the psychiatric technician. The nurse can make rounds in the absence of the physician, can decide when the physician should be called, and can be responsible for the dispensing of medications. She should in all possible ways release the time of the ward physician so that he can devote himself to patient treatment. This can be accomplished without her interfering with the function of the psychiatric technician nor assuming a supervisory role with respect to that category of personnel.

In most hospitals, both nurses and psychiatric technicians are burdened with housekeeping and with clerical tasks which wastefully consume time which should be used for patient care. They should be relieved of these inappropriate assignment.

Preserving the Dignity of the Patient

Considering the size of the patient population in the State hospitals and the fact that a high proportion of these patients are chronically ill, hospital personnel manifested a commendable degree of concern about the individuality of the patient and his dignity as a human being. There were, however, a number of instances in which physical limitations interfered with this consideration or in which the staff seemed to have become sufficiently case-hardened to ignore conditions which were observed by the visiting physicians.

In most hospitals there was evidence of appalling over-crowding, particularly in wards which house geriatric patients and those who are chronically ill. There was so little space between beds that it was impossible to allocate an individual bedside table or cabinet to each patient, and accordingly the patient was unable to keep his personal belongings at hand and was, in effect, stripped of his individuality. Crowded conditions in the ward made privacy virtually unattainable.

Within the context of industrial therapy, many patients perform work which is important to the day-to-day operation of the hospital. Generally speaking, an effort is made to assign patients to work stations in accordance with therapeutic benefits which might be derived by the patient. It is suggested, however, that a modest (although not degradingly small) reimbursement to patients for such work would improve morale. This would be particularly desirable because in many hospitals the allotment of cash per patient for personal needs is extremely low (in at least one hospital, \$5.00 per year).

Financial limitations make it difficult to provide hearing aids and eye glasses for geriatric patients; this imposes a communications deficit which emphasizes the sense of isolation of the psychiatrically disordered.

In many instances it was noticed that patients used communal hand towels. These should be replaced either by paper towels or (preferably) by air blowers.

Several hospitals offered promising programs of adult education for selected patients. It would seem that this would not only contribute to the improved morale of the patient while he is hospitalized but might bolster his efforts at rehabilitation after discharge. Consideration might be given to providing incentive pay to patients who avail themselves of such opportunities, comparable to the pay proposed above for industrial therapy.

Medical and Surgical Services

Adequate facilities and equipment should be available on all wards for physical examinations. The lack of these was noted particularly in wards with geriatric patients. Proper space with the necessary privacy should also be provided for psychiatric evaluations.

Pelvic examinations and Pap smears should be included as part of the annual physical examination of all female patients.

The hospitals adhered to no consistent policy with respect to patients' charts. In several hospitals, they were kept in a central record room, with only a summary of information available on the wards. It is suggested that charts on the wards duplicate in all detail information contained in the central record room, so that any physician working in the ward will have immediately available a complete medical and psychiatric evaluation of the patient.

The possibility should be explored of a hospital's contracting for medical and surgical services from the medical resources in the community, rather than providing them directly, particularly for those hospitals who have difficulty recruiting medical staff and who have limited facilities and equipment.

Shifting Pattern of Patient Population

In accordance with the long-range plans of the Department of Mental Hygiene, an increasing number of patients are being moved out of mental hospitals after short-term, intensive treatment and are either being placed in foster homes in their own communities or are assigned to out-patient treatment facilities closer to their homes. This is a commendable trend and one which we wholeheartedly support. It should be noted, however, that as the patient population of hospitals decreases, hospital administrators are contemplating parallel reductions in staff, and we wish to point out some of the hazards of this practice: First, the residual patient population after such transfer is made up of the patients who are least self-sufficient and require the greatest amount of attention from the staff, particularly the psychiatric

technicians. Second, the patients who are transferred out of the hospital have in many instances been extremely helpful in assisting in the care of fellow-patients who are more severely disabled; accordingly, the work load of the hospital staff becomes greater rather than smaller after they leave. Third, it is demoralizing to staff to be "rewarded" for the success of their effort on behalf of the patients by being discharged from their jobs.

It was noted that when a hospital has empty beds or when it has new units opening up, patients from over-crowded hospitals are transferred to it. Several disadvantages to this practice might be pointed out. The transferred patients are frequently those whom the initiating hospital finds "hard-to-handle"; in effect, a hospital which succeeds in reducing its own patient population is penalized by having assigned to it the most intractable patients from other hospitals. If the transferred patients are not in the hard-to-handle category, their transfer is still a dubious practice, since the institution at which they were initially hospitalized is usually the one closest to their homes. The patient thus transferred becomes further isolated from his community, and his ultimate rehabilitation becomes more difficult.

It seems highly probable that many geriatric patients in State mental hospitals are more disabled by physical infirmities than by psychiatric disorders. It is suggested that the Department of Mental Hygiene intensify its program of re-evaluating these patients so that those who do not need intensive psychiatric treatment in a hospital setting can be placed in nursing homes.

Special Considerations with Respect to Patients Under Age 16

In the hospitals in which the patient population includes persons under the age of 16, it is recommended that services for this group of patients be separated to whatever extent feasible from the services provided the adult group. The young patients should have the benefit of treatment programs specifically designed for their age category, should be attended by professional personnel geared to their problems, and should be housed in separate quarters. It is suggested that in formulating treatment for young patients, the use of outside consultants in child psychiatry could advantageously be utilized.

A special effort should be made to develop additional resources such as foster homes and halfway houses to facilitate the movement of children out of hospitals and to forestall chronicity.

Hospitals which have children's units should have better liaison with the Juvenile courts as well as other community agencies, so that patients sent to the hospital by the courts for observation are appropriately selected; there is adequate follow-up after discharge; and alternate solutions are developed for children for whom hospitalization is not the best course of action.

Facilities

Generally speaking, the standards with respect to the physical facilities were adequate, and a commendable concern for maintenance was observed. Cleanliness, particularly with respect to kitchens, dining areas, and wards with bed-ridden patients was noted.

The crowded conditions already alluded to earlier in this summary constituted a recurrent problem.

A few of the older hospitals occupying structures which were not originally intended for mental hospitals have special problems which perhaps cannot be solved in any way except by abandoning the installation for more suitable quarters. Buildings are large and are far apart. Units are isolated from each other, and this isolation interferes with professional esprit de corps. Valuable time is wasted by professional personnel in walking down interminable corridors, and in some instances the distances to be covered might well create a serious delay in getting to a patient.

Hospital personnel generally seemed aware of the necessity for safety measures and for adequate preparation in case of fire or other disasters, but this awareness sometimes seemed theoretical and untested by experience. It is suggested that all disaster measures be carefully reviewed with two specific considerations in mind: it is important that each staff person with patient responsibility in case of disaster know in detail exactly what must be done, and in what sequence, in case of fire; since fire-fighting equipment will in many cases be handled by female employees, it should be re-examined to make sure that it can feasibly be managed by them.

Week-End Staffing

Mental illness and its treatment cannot be geared to a five-day week or an eight-hour day. Hospitals are urged to re-examine their personnel practices in this respect and to assign staff members on a staggered schedule so that coverage is uniform throughout the week.

In a few instances, there was evidence that coverage during the night hours for psychiatric as well as medical/surgical services was so limited that it could not be assumed that emergencies could be properly treated.

Even more acute was the shortage of staff during week-ends, particularly with respect to admission of new patients. In some hospitals, patients being transferred from county hospitals or ordered to the hospitals by the courts arrive over the week-end when the hospital is least equipped to process them. Patients who are severely depressed or highly agitated spend a threatening interval with neither evaluation nor treatment. In some cases, it is necessary to medicate these patients so heavily that by the time they are seen by psychiatric personnel, the true nature of the disorder may have been obscured.

It should also be kept in mind that the week-end is the time during which members of the family are most likely to visit patients. Attending psychiatrists and ward physicians should be available during that time for family conferences.

After-Care Programs

Most hospitals maintain excellent after-care programs which enable patients to test their level of recovery by returning to the community and still retain a measure of supervision from the hospital staff.

In the after-care program as in the hospital treatment program, the continuing availability of drugs is of paramount importance and must be safeguarded.

The after-care program is of particular benefit to those patients whose homes are close enough to the hospital so that they can readily return for services. In some cases, however, hospitals draw their patient population almost entirely from urban centers, and it is rarely feasible for on-leave or discharged patients to return to the outlying area for hospital after-care. Some consideration should be given to making after-care services available not only at the hospital itself but also (even though on a limited basis) in these urban centers.

Many recovering patients are eager to resume work when they leave the hospital. The extent to which they can derive professional support from an after-care program is limited in hospitals who operate these programs on an eight-hour day. It is suggested that psychiatrists and social workers be available during evening hours and on week-ends to provide after-care services.

Special Considerations with Respect to the Mentally Retarded

The State-wide special education classes for mentally retarded children who are classified as either educable or trainable constitute one of the most valuable treatment resources for these disabled persons. Yet mentally retarded children who are hospitalized within the State system are not always provided the opportunities for development which these classes offer. Shortage of teachers and lack of classroom space handicap these programs. (To a less marked extent, this shortage of educational facilities was also observed in general psychiatric hospitals which had patients under age 16). It is urged that the Department of Mental Hygiene create a central staff position filled by professional educator to provide direction and maintain standards with respect to all school programs. Closer liaison between the Department and State education officials is also suggested, with particular reference to properly staffing the special education classes in hospitals for mentally retarded.

Although it is not assumed that the condition is pervasive, among the children in hospitals for the mentally retarded were some patients who were

clearly psychotic rather than retarded. This suggests that the screening procedures in these hospitals could be improved. With respect to the psychotic patients already hospitalized in these institutions, it is urged that special treatment programs be developed for them.

In the pre-employment screening and in the hiring of psychiatric technicians, no differentiation seems to be made between those who will be caring for the mentally ill and for the mentally retarded. As a result, technicians who are not temperamentally suited to dealing with the problems of mental retardation or who are not particularly interested in this category of patients are often assigned to hospitals for the mentally retarded. It is suggested that testing and hiring be more sharply pinpointed so that technicians assigned to the mentally retarded are more appropriately selected. In view of the fact that the psychiatric technician carries significant responsibilities with respect to the mentally retarded - - in terms not only of physical care but of emotional support - - it is suggested that their in-service training program be intensified.

Special Considerations with Respect to Day Treatment Centers

The Department of Mental Hygiene has established day treatment centers in three urban communities as part of a pilot program to determine whether certain types of acutely ill patients can avoid hospitalization, and instead be aided to improvement through out-patient participation in a therapeutic milieu.

Experience with this type of facility is still relatively limited, but its objectives are psychiatrically sound and the opinions of the visiting physicians were that all three centers were functioning effectively and had already made a therapeutic contribution. We recommend that additional day treatment centers be established.

To strengthen the day treatment program, it is suggested that:

1. Emphasis on family therapy be extended.
2. Treatment be available to patients under age 16.
3. Record-keeping and post-discharge follow-up be improved.
4. The centers be utilized as training setting for psychiatrists, psychologists, social workers, and nurses.

SUMMARY

It is significant to keep in mind, while evaluating the state mental hospital system, that the system itself is in the process of transition, with increased emphasis on the development of community services and treatment by local professional resources. A State hospital is no longer perceived as a center for a total treatment program. To an increasing extent, inpatient treatment of acute psychiatric disorders is being provided in the patient's home community. Aftercare programs, too, are being developed as local programs. The State system has initiated a successful demonstration program with respect to day treatment centers, and additional facilities of this type, under public and private local sponsorship, will make it possible for many seriously disordered patients to be treated as outpatients rather than inpatients.

As these shifts in the total pattern of mental health services occur, we anticipate these changes to be reflected in the function and staffing of State hospitals. Patients who are in these hospitals for short-term intensive treatment will require the services not only of professional persons qualified to administer therapy, but also of persons skilled in the techniques and processes of integrating the post-hospitalized patient with the resources of his community.

The patient population of State hospitals will, to an increased extent, be made up of persons with chronic disorders. Many of these patients may manifest enough improvement to return to their communities, but of these, a certain proportion can be expected to require rehospitalization. Treatment emphasis will be less on intensive therapy than on rehabilitation and social restoration so that periods of remission from illness can be as productive and satisfying as possible.

The observations derived from this study indicate that there should be stronger and more sustained interchange between members of the medical profession on State hospital staffs and those in the outside community. We are convinced that the isolation which is imposed upon the medical staffs of State hospitals is not of their choosing, and those of us who practice medicine privately offer our resources to help break down this isolation. Several concrete recommendations have already been advanced: liaison between hospital staffs and county medical societies; utilization of more community physicians as consultants in teaching programs and on ward service; participation of hospital staff in educational meetings away from the hospital site. To strengthen this interchange, we propose that the physicians who served on our survey teams meet jointly with the combined hospital staffs to discuss the results of this initial survey openly, candidly, and informally.

Finally, we would like to suggest that the survey which is herewith

being reported be perceived as the first step in a continuing process. We recognize that each of the hospitals we visited is in the process of undergoing changes, and that these changes will not necessarily follow parallel lines nor proceed at similar rates. But we think that objective, dispassionate appraisal is a sound accompaniment to change, and we would willingly accept as part of our professional responsibility, a re-evaluation of the State hospital system at regular intervals. In a subsequent study, we would like to investigate in greater depth the efficacy of various treatment programs, and to this end, we hope that comprehensive statistics will be made available to us concerning the types of patients who are hospitalized in State facilities, in terms of socio-economic backgrounds and in terms of psychopathology. We would also find it helpful to be provided with follow-up reports of what happens to patients after they leave State hospitals.

We believe that patients in State mental hospitals need all the insights and all the therapeutic vigor which can be provided by both the private and the public sectors of medicine. The recommendations of this report are a means of channeling our contribution to meet this need.

are concerned with the patient's achieving self-understanding, rather than serving primarily as a medium for the exchange of opinions and feelings.

6. The psychiatric technicians on the female wards should be provided with the same kind of in-service training which has already been given the technicians on the male wards.

7. The ill-defined complaints with respect to the head of the nursing service should be explored and attempts made to resolve the problems existing in that situation.

8. Female patients receiving ECT should be provided the same premedication now being given male patients.

9. The facilities and personnel for OT should be better utilized, both in the shops and on the wards.

10. Attempts should be made to obtain foster home placement for further benefits from a hospital regimen.

11. Visiting doctors who see patients on the wards should be required to sign the ward logs.

12. All staff committees which have been established should be activated; the combination of committee functions should be undertaken to streamline staff activities where this can be done without jeopardizing approved hospital procedures.

13. Provision should be made for regular and sustained interchange among members of the professional staff.

14. The possibility of giving token pay to patients who help perform the work of the hospital should be explored.

15. Provision should be made for placing in separate rooms those patients who should be isolated.

16. The surgical area should be separated from the out-patient clinic.

17. The maximum security area should be provided better protective devices so that it serves the function which its name denotes.

MENDOCINO STATE HOSPITAL

MENDOCINO STATE HOSPITAL

Ukiah

Superintendent and Medical Director: E. W. Klatte, M.D.

Rated Capacity: 2,293

Four psychiatrists and one surgeon visited this hospital on October 3 - 4, 1964. These physicians were selected from the communities of Palo Alto, San Francisco, and Burlingame.

This is the principal State hospital serving the large rural area in the Northwest portion of California. In terms of function and administration, the hospital consists of four areas: Admission and Acute Psychiatric Area, Geriatric and Medical-Surgical Area, Women's Continuous Psychiatric Treatment and Alcoholic Area, and Men's Continuous Psychiatric Treatment and Alcoholic Area.

Physical Plant

Everything about the physical aspect of this hospital was extraordinarily commendable. The grounds were attractive, the buildings in a good state of repair, and the over-all level of cleanliness and sanitation could not be faulted.

Kitchen facilities were good, proper sanitary measures were observed there, and the patients who served as kitchen helpers seemed responsible and cooperative. There was no evidence of over-crowding in the wards.

Satisfactory provision was made for the isolation of patients with communicable diseases.

The patients were adequately dressed, and their clothing (particularly for the women) was agreeably free of the stigma of institutionalized uniformity.

The examining rooms seemed adequate and well equipped with a single exception; facilities in the geriatric area were limited and were not equipped for gynecological examinations.

Perhaps no more telling evidence could be cited concerning the importance the hospital attached to its physical environment than the care which is given incontinent patients. Since the hospital has an over-sixty-five population of approximately five hundred patients, incontinence could be expected to present an acute problem, and one concerning which attendants might be expected to get somewhat calloused. These expectations were not borne out; patients in this category were bathed frequently, their bedding was changed often, and a decent degree of importance was attached to their comfort and dignity.

Two shortcomings were noted with respect to the physical plant: (1) The hospital had only one bus for the use of both patients and staff; the use by patients is primarily for those in the process of rehabilitation who are making excursions into the community. The single bus was inadequate to the needs. (2) The occupational therapy area was too small, and there were not sufficient funds to provide materials for this activity. Some materials were provided by the patients, some improvised; a more generous budget for materials would improve this program.

Personnel

The hospital could advantageously use more psychiatrists, particularly at the senior level. A board-certified internist was in charge of the medical service. The surgical service, which had previously had as its chief a full-time surgeon, was at the time of the survey the responsibility of one who devoted part-time to the hospital and part-time in private practice in Ukiah. Part-time visiting physicians functioned in pathology, radiology, urology, orthopedics, ENT, and ophthalmology.

There were six trained persons in the psychology service; it was reported that recruitment of psychologists is difficult not primarily for economic reasons but because most recent graduates in the field feel there is more prestige to be derived from a practice devoted to individual psychotherapy. The chief of the psychology service was also chief of research for the hospital. It seems plausible that he may be spreading himself too thin; this was particularly apparent in the geriatric area, where psychologic services were minimal.

The social workers performed the traditional assignments of maintaining liaison with the patients' families and facilitating discharge plans, and in addition, functioned, to some extent, in group therapy, community service, and a variety of hospital projects. They seemed to be resourcefully utilized beyond their case work function.

The hospital needed more psychiatric technicians, social workers, and nursing supervisors. The supply of registered nurses seemed adequate except for week-end coverage and in the geriatric area.

The foregoing enumeration of the quantitative deficits in personnel fails to reflect the very positive qualitative aspects. In every area of the hospital visited by the survey team, and at both professional and ancillary levels, the calibre of personnel was outstanding and its morale was exceedingly high.

Everyone on the staff who functions in direct relationship to the patients therapeutically demonstrated a high level of enthusiasm; they were well informed about all the patients and interested in their well-being and progress. At the non-treatment level, personnel was pleasant and helpful. Everyone at the hospital manifested impressive loyalty and pride; all seemed to have an emotional investment in the hospital, and to derive gratification from identifying with an effective treatment program and with a superintendent who provides vigorous leadership.

The level of pay generally is high when compared with the prevailing level in the rural community in which the hospital is situated, but this is not the significant element in relation to morale. Good professional people are attracted to the hospital because they are convinced that it provides them with opportunities for professional development.

A good in-service training program was provided the ancillary staff, and it was well utilized. Opportunities were available for additional training at sites other than the hospital itself; it is recommended that more time (and in some instances, funds) be made available to the staff so that they can take advantage of these nonhospital programs.

The residency training program was excellent. Consultants associated with the hospital functioned in the teaching program and participated in ward consultation.

The relationships between the medical and the technical staffs were good. Perhaps as contributory to the morale and esprit as any single factor was the fact that the professional personnel in this hospital feels it has the freedom to disagree.

Psychiatric Services

The hospital was very treatment-oriented, and the entire milieu was eminently therapeutic.

It was observed that a wholesome and relaxed rapport existed between patients and staff. There was no evidence of regressed patients sitting about the wards apathetically, nor were patients over-sedated. No acutely disturbed or destructive patients were seen.

The modalities of therapy included individual psychotherapy, group therapy, re-education therapy, industrial therapy, occupational therapy, and recreation therapy. The individual therapy was conducted by the younger psychiatrists and in some instances by social workers; in all instances there was senior psychiatric supervision. Group therapy was under the direction of psychologists, social workers, and psychiatric technicians.

Drugs were used actively and discriminately, all drug orders were reviewed regularly. (Only one exception was noted; in one ward, geriatric patients were given sodium amytal IM PRN.) Drug dosages were decreased or eliminated for patients who had been in treatment for a period of time. The budget for drugs for in-patient use was adequate. However, the hospital also undertook to supply medication to patients in their after-care program. For this, the budget was inadequate; there were additional limitations because the welfare formulary does not permit providing tranquilizing drugs for psychiatric disorders.

Electro-convulsive therapy was used very conservatively - - as an emergency treatment, as a limited program for severe depressions, or in maintenance dosages for some chronic patients. When it was used, muscle relaxants were employed and post-shock x-rays were taken when indicated.

Charts were complete and were available on the wards, rather than in a central record room, so that a patient's progress could be promptly evaluated. Charts included all patient incidents, which were investigated promptly.

The hospital had a good after-care program and an effective rehabilitation program. Its staff placed great emphasis on vocational placement after discharge.

Residents spent approximately one-half their time in training activities and the other half on the wards. The amount of time the psychiatrists spent with patients varied widely, but the entire staff was very patient-oriented, and some psychiatrists spent as much as thirty hours a week in direct work with patients.

Use of restraints was minimal. They were used only when ordered by a physician, always on a time-limited basis, and orders were subject to review by the chief of service. Maximum security facilities seemed adequate, humane, and well supervised; they were not used punitively but essentially to insulate other patients from intolerable psychopathological behavior. One exception to the otherwise discreet use of security devices was noted during a night visit to one of the units where seven small dormitories, each housing approximately twenty-eight patients, were all locked. Although technicians stated that they made rounds at frequent intervals, it was felt that keeping patients behind locked doors in this manner was both a safety and a psychological hazard.

Great emphasis was placed on returning the patient to the community as soon as possible. This was evident even among the geriatric patients; in three months prior to the survey, ninety per cent of geriatric patients admitted were returned to the community directly from the Admission Unit, without long-term treatment.

The medical director was kept constantly informed concerning the condition of all patients. He received monthly progress reports, made frequent ward rounds, and participated in consultations.

The women alcoholic patients registered understanding and support of the treatment program they were undergoing. It was understood that a comparable program for male alcoholics was not equally successful, but no direct evaluation was made.

The professional staff of the hospital expressed itself as being less than satisfied with its treatment program for adolescents, but they were in the process of re-examining it at the time of the survey. Consultants from the field of child psychiatry might be advantageously utilized in this respect.

A number of the patients in the geriatric area were more disabled by physical infirmities than by psychiatric disorders. It is recommended that they be re-evaluated, and that those who could be more appropriately treated in nursing homes be relocated.

Extensive facilities for recreation therapy were available, but they were inadequately utilized.

Throughout the hospital, patients were in constant contact with therapeutic personnel. In some wards, each patient was assigned a nurse, a psychiatric technician, or some other staff member to serve as counsellor. The patient, accordingly, could not validly feel abandoned, and was constantly reassured by evidence that the focal point of the entire hospital was recovery and return to normal living.

Medical and Surgical Services

Bylaws, rules and regulations were clearly stated, and the privileges and duties of staff members were well defined.

Three wards, each with approximately thirty beds, were allocated to medicine, surgery, and orthopedics. There were also operating rooms, a dental clinic, an outpatient specialty clinic, and a clinical laboratory. The laboratory can do clinical chemistry, bacteriology, serology, and pathological examinations including frozen sections. The hospital had an adequate blood bank.

Medical records were written promptly and in detail, and were available on the wards.

Surgical facilities were adequate and properly equipped for general surgery, emergency service, orthopedics, and emergency neuro-surgery. However, because at the time of the survey the hospital did not have a full-time surgeon, there was a backlog of surgical cases (17 major and 34 minor). Lack of funds for materials and equipment seemed to contribute to this backlog, which included several possible malignancies and instances in which patients were experiencing continued discomfort because of lack of surgical treatment.

The physicians with ward responsibility for geriatric patients seemed conversant with the medical and surgical problems of the aged and infirm.

When physical examinations were done on the psychiatric wards (in contradistinction to those done in the medical area) it was not the practice of the staff to do pelvic examinations upon female patients. We recommend that pelvic examinations and periodic Pap smears be included in these examinations.

The supply of drugs was adequate for treatment of nonpsychiatric as well as psychiatric disorders.

Weekly medical-surgical staff meetings were held, attended by part-time as well full-time physicians, by consultants, and by the pathologist and the radiologist. Discussion included not only hospital cases of interest, but also significant cases seen by consultants elsewhere in their practice.

Full-time staff physicians attended an additional weekly staff meeting, devoted in large part to discussion of nonmedical problems of the hospital.

A monthly CPC was reportedly held, but minutes were not examined.

A Patient Care Committee, meeting regularly, functioned as a Credentials Committee and a Joint Conference Committee. It was attended by chiefs of service and key nonmedical personnel, such as chief of nursing, personnel officer, and hospital business administrator.

A Medical Records Committee was active and vigilant; its standards were reflected in the splendid calibre of medical records.

There were a Tissue Committee and a Tumor Board, whose last meeting apparently had taken place approximately three months prior to the survey. However, all tissue removed is examined by the pathologist, and apparently his reports are included in the weekly medical-surgical meeting. This meeting also seems to assume the responsibilities of a Medical Audit Committee, since no separate group is provided for in this category. Other hospital committees whose minutes were presented for examination included a Professional Library Committee, a Pharmacy Committee, a Journal Review Committee, and a Research Committee.

Anesthesia was administered by a nurse anesthetist. Dental examinations are undertaken at the time the patient enters the hospital. The dental department was equipped to provide both emergency and maintenance services.

Wards were under the supervision of registered nurses. Nursing conferences were held regularly.

An enthusiastic and cooperative relationship was evident between the full-time and the part-time physicians. There was a high level of interest in practicing good medicine and in continued professional education.

General Observations

The director of the hospital was cooperative, informative and nondefensive in working with the survey team. The impression gained was that he is a capable psychiatrist and a competent administrator who is proud of his hospital.

The hospital aspires to be regional mental health facility, and to a commendable degree, achieves this objective. However, one of the deterrents is the fact that since it is less crowded than many of the other State hospitals, it is often the recipient of mass transfer of patients, including "bottom of the barrel" cases from the remote communities. Many of these transferred patients have no homes to which they can be released; this frustrates the return-to-the-community orientation of the hospital's program. It is recommended that the foster home program be strengthened so that patients ready to leave the hospital are not kept there because they have no other place to go. Included among the patients assigned to Mendocino are alcoholic patients from San Francisco, usually those without families. They are, at best a difficult treatment problem, and since rural Mendocino County is not their home community, a smooth post-hospital transition cannot be arranged for them as readily as for other patients.

Shortage of funds was evident in a number of instances in which either hardship or humiliation was inflicted on patients. The allowance given a patient when he goes on leave or is discharged is so inadequate that patients often return to the hospital for purely economic shelter. Only \$5.00 a year is allowed per patient for personal needs, although the hospital estimates that expenditures by patients average \$36.00 per year in this category. Patients in industrial therapy were paid at the appallingly low rate of \$1.00 per month, and sometimes even less. This tends to offset whatever sense of worth they might derive from the work they do; increasing this rate of pay would not only be therapeutic for the patient but would help him pay for his own personal necessities. The hospital lacked funds for hearing aids, eyeglasses, and dental prostheses. The latter are particularly important because of the high ratio of geriatric patients. The lack of hearing aids and eyeglasses imposes a communication deficit which exacerbates the sense of isolation of the psychiatrically disordered.

The hospital assumes a major role in the mental health program of the community, with respect to mental health education, psychiatric ward services in general hospitals.

It is recommended that this laudable program be backstopped with additional funds, so that hospital teams, each consisting of a psychiatrist, a charge nurse, a social worker, and a psychologist, could intensify community services.

Summary of Recommendations

1. A full-time surgeon should be on duty, and such additional funds are necessary should be provided for materials and equipment in order that the surgical backlog can be reduced.
2. Personnel expansions are recommended in the following categories: psychiatrists, psychologists, social workers, psychiatric technicians, nursing supervisors.
3. Geriatric patients should be re-evaluated, and those whose needs can be met by nursing home facilities should be relocated so that hospital facilities can be allocated to those requiring intensive psychiatric treatment.
4. So long as the present practice continues of transferring to this hospital persons from other communities, and particularly persons with no homes to which they can be released, the foster home program should be strengthened.
5. Consultants from the field of child psychiatry should be utilized to enable the staff to improve its treatment program for adolescents.
6. The budget for drugs for use in the after-care program should be expanded.
7. Such additional financial support as is necessary should be provided to expand the hospital's community services in the field of mental health.
8. Additional funds should be provided as allowances to patients on leave and at time of discharge; to enable patients to purchase personal necessities; and to furnish patients with hearing aids, eyeglasses, and dental prostheses.
9. Equipment should be available to conduct gynecological examinations in the geriatric wards.
10. Examination of female patients on the psychiatric wards should include pelvic examinations and Pap smears.
11. Additional transportation facilities are needed for use by patients and personnel.
12. The Occupational Therapy area should be increased and provided with more materials.
13. Better utilization of recreation facilities is recommended.

METROPOLITAN STATE HOSPITAL

PRE-VISIT QUESTIONNAIRE

Hospital Questionnaire

1. General Information

1. Name of Hospital _____
 Location: _____
 Medical Director: _____

2. Rated Capacity: _____

Number of wards and beds in each classification:

<u>(Mentally Ill only)</u>	<u>Wards</u>	<u>Beds</u>
1. Receiving and Initial Treatment	_____	_____
2. Psychiatric Treatment - adult	_____	_____
3. Medical Surgical Geriatric Bedridden Acute Tuberculosis	_____	_____
4. Psychiatric Treatment - children	_____	_____

3. Rated Capacity _____

Number of wards and beds in each classification:

<u>(Mentally Retarded only)</u>	<u>Wards</u>	<u>Beds</u>
A. Admission, Intensive Psychiatric Treatment, Intensive Pediatric (under 6) Medical and Surgical, Contagious Research	_____	_____
B. Patients aged 6-18 continuous treatment - infirm - not bedridden	_____	_____
C. Adult Rehabilitation and Habit Training	_____	_____
D. Vocational Training	_____	_____

4. Distance to nearest General Hospital _____ miles

5. Dates of last two inspections of hospital by:

APA	_____	_____
Joint Commission on Accreditation	_____	_____
State Department of Mental Hygiene	_____	_____
Bureau of Hospitals (SDPH)	_____	_____
Fire Marshall	_____	_____

(Please attach copy of inspection report for each)

6. 1962 Statistics

Length of Stay: Deaths Discharged

Less than 3 months	_____	_____
3 - 6 months	_____	_____
7 months to 1 year	_____	_____
1 - 2 years	_____	_____
2 - 3 years	_____	_____
4 - 5 years	_____	_____
Over 5 years	_____	_____

Type of Admission: Total Male Female Children(under 16)

Voluntary	_____	_____	_____	_____
Emergency	_____	_____	_____	_____
Temporary	_____	_____	_____	_____
Observation	_____	_____	_____	_____
Court Commitment	_____	_____	_____	_____
Health Officer	_____	_____	_____	_____
Physician Certified	_____	_____	_____	_____

7. Number of patients (May 1, 1963):

Alcoholic	_____
Narcotic Addicts	_____
Epileptics without mental retardation	_____
Mentally Ill	_____
TB	_____
Juvenile Court Observation Cases	_____
Mentally Retarded	_____
Others: (list)	_____
Criminals (serving sentence)	_____

8. Statistics on Hospital Patients:

<u>Year</u>	<u>Average Number Patients</u>	<u>First Admissions</u>	<u>Read-missions</u>	<u>Total Discharged</u>
1962	_____	_____	_____	_____
1961	_____	_____	_____	_____
1960	_____	_____	_____	_____
1959	_____	_____	_____	_____

9. Number of deaths (in-patients);

(a) 1962 _____ 1961 _____ 1960 _____

(b) of 1962 group, give age:

Age 1-5 _____ 21-30 _____ 51-65 _____
 6-10 _____ 31-40 _____ 65-over _____
 11-20 _____ 41-50 _____

10. Annual Autopsy Rate:

1962 _____ 1961 _____ 1960 _____

11. Number of suicides: 1962 _____, 1961 _____, 1960 _____,

12. Is there a Chapel: yes _____ no _____; Resident Chaplain: yes _____ no _____

How frequently are services held _____; for "shut-ins" _____

13. Average cost per patient for year:

1962 _____ 1959 _____

1961 _____ 1958 _____

1960 _____ 1957 _____

14. Does the hospital maintain a farm? yes _____ no _____

Number of patients assigned there _____

2. Patient Information

1. Resident population occupying beds as of midnight, May 1, 1963:

	Total	Male	Female
under 15	_____	_____	_____
16 - 19	_____	_____	_____
20 - 39	_____	_____	_____
40 - 59	_____	_____	_____
60 - over	_____	_____	_____
Total	_____	_____	_____

2. Are all newly admitted patients photographed yes _____ no _____
fingerprinted yes _____ no _____

Are all patients' photographs and fingerprints filed: in the

Medical Records Department? yes _____ no _____
with ward chart? yes _____ no _____

3. Do all patients receive:

a. Physical examination on admission (partial _____, complete _____)
re-examination: every 6 months _____, every year _____,
every 2 years _____, on release _____.

b. Dental examination on admission _____, re-examination _____.

c. Psychiatric evaluation on admission _____.

Re-evaluation: every 6 months _____, every year _____,
every 2 years _____, on release _____.

d. List routine lab and X-ray procedures done on admission:

4. How many patients are currently involved in:

individual therapy _____
group therapy _____
occupational therapy _____
industrial therapy _____

5. Are all orders for restraint and seclusion written and signed by a physician?
yes _____ no _____

How frequently must seclusion orders be reviewed: _____

6. How are patient complaints handled? _____

Staff Information

1. Ratio of actual registered nurses to patients in each ward category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

2. Ratio of actual Psychiatric Technicians to patients in each category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

3. Ratio of actual Psychologists to patients in each ward category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

4. Ratio of actual Industrial Technicians to patients in each category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

5. Ratio of actual Recreational Therapists to patients in each category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

6. Ratio of actual Music Therapists to patients in each category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

7. Ratio of actual Occupational Therapists to patients in each category

	Mentally Ill			Mentally Retarded		
	Day shift	Second shift	Third shift	Day shift	Second shift	Third shift
1. _____	_____	_____	_____	A. _____	_____	_____
2. _____	_____	_____	_____	B. _____	_____	_____
3. _____	_____	_____	_____	C. _____	_____	_____
4. _____	_____	_____	_____	D. _____	_____	_____

8. Ratio of actual Therapists to patients:

Psychiatric (acute and continued treatment) _____
 Medical Geriatric _____
 TB _____
 Admission alcoholic _____
 Children (age 0-18) _____
 Mentally Retarded (Lower age, lower IQ) _____
 (Upper age, upper IQ) _____

9. Number of medical staff members:

Active (Full time): List name, duration of employment, Board certified, Board eligible, specialty on separate attachment. (average turnover last year (number of authorized vacancies

Consulting Staff (list information as requested above) Courtesy Staff (list information as requested above) Associate (list information as requested above) Others (list information as requested above)

How is consulting staff utilized: (describe)

Number of dental staff members: (List information on separate attachment)

Active (Full time): List name, duration of employment Courtesy (List information) Associate (List information as requested above)

10. Number of Registered nurses: Full time, Part time, Classification of each. (List on separate attachment)

(average turnover last year (number of authorized vacancies

11. Number of psychiatric nurses number of vacancies

12. Medical Staff Bylaws, Rules and Regulations (attach copy)

a. Date written b. Date last revised

12. Manual of Nursing Services (attach copy)

a. Date written b. Date last revised

13. Manual of instruction for Psychiatric Technicians (attach copy)

a. Date written b. Date last revised

14. Policy regarding leave to attend/participate in professional society meetings/postgraduate education.

Number Days per year

Physicians Nurses Dentists Therapists Technicians

15. Number of Social Workers

Number of vacancies

16. Number of Teachers

Number of vacancies

4. Medical Information

1. Amount of money spent last 2 years on direct patient medical care:

Table with columns for 1962 and 1961, and rows for Consultants, Drugs, Med. & Surg., Supplies, New equip.

2. Automatic stop order on dangerous/addicting drugs? yes no (attach copy of staff directive)

3. Is there "registered pharmacist" yes no Full time Part time

4. Are drugs kept on wards in locked cabinets Who has access to drugs

5. Is there an isolation ward for contagious diseases yes no Describe:

6. What immunization procedures are routine on admission:

7. How many cases of contagious diseases were isolated during 1962:

Describe:

5. Employee Information

1. How are employees complaints handled?

2. Number of separations during 1962:

Table with columns for Total, Voluntary, Forced and rows for Male, Female

What is basis for separations?

3. Are all employees given listed immunizations and special tests:

Typhoid, Paratyphoid, Small pox, Diphtheria, Scarlet fever, Measles, Chest X-ray, Stool, Complete physical exam, partial exam, Serological test for syphilis, Annually: yes no

4. How many disciplinary matters were handled by the policy committee last year?

3. Who directs training program:

- a) Psychiatric nursing: Title b) Residency training: Title c) Psychiatric technicians: Title d) Registered nurses: Title e) Psychologists: Title f) Social Workers: Title g) Rehabilitation Therapists: Title

4. Facilities for teaching: class rooms, demonstration room, lab, office

5. Research: a) Name of Director and professional qualifications

b) Is there a Research Committee? yes no

c) How many staff participate?

6. Training, Postgraduate Education and Research

1. Actual funds spent:

Physician Postgraduate Education/Professional Society meetings:

Table with columns for 1962 and 1961, and rows for Nursing, Therapists, Dentists

2. Does hospital have approved psychiatric residency program? yes no

others:

TEAM GUIDE

Team Guide

1. Physical Plant

1. Clean and Sanitary? _____
2. In good state of maintenance? _____
3. Facilities for a. segregation of patients by service _____
b. isolation of patients _____
c. adequacy of (a) and (b) _____
4. Dining and kitchen facilities: adequate _____, clean _____, sanitary _____
5. Examining rooms and equipment: (Ward level/ Receiving and Treatment)
Appropriate Number Properly Equipped
a. Psychology: yes ___ no ___ yes ___ no ___
b. Medical: yes ___ no ___ yes ___ no ___
6. Facilities for isolation of patients with communicable diseases:
_____ ; obstetrical _____ ; new born _____ ; pediatrics _____
7. Emergency lighting provisions:
a. operating room _____
b. delivery room _____
c. nursery _____
d. emergency room _____
e. stairwells _____
f. wards and rooms _____
8. Adequate beds for patient load _____

2. Personnel

1. Are following represented on Staff:
 - a) Physicians:
 1. psychiatry Number _____
 2. surgery Number _____
 3. internal medicine Number _____
 4. pediatrics Number _____
 5. Ob/Gyn Number _____
 6. general practice Number _____
 7. pathology Number _____
 8. radiology Number _____
 9. Orthopedic surgery Number _____
 - b) Psychologists Number _____

- c) Dentists Number _____
- d) Nurses:
 1. registered Number _____
 2. psychiatric Number _____
 3. surgical Number _____
 4. Ob Number _____
- e) Psychiatric Technicians Number _____
- f) Therapists
 1. physical Number _____
 2. occupational Number _____
 3. recreational Number _____
 4. industrial Number _____
 5. music Number _____
- g) Social workers Number _____
- h) Teachers Number _____
- i) Pharmacists Number _____

2. Do personnel appear to be proficient in performing assigned tasks? yes ___ no ___
Exceptions/Deficiencies (explain) _____

3. Do personnel (in general) appear to have high morale? yes ___ no ___
Explain _____

4. Do personnel have adequate and up to date equipment necessary to perform at optimum level of patient care and treatment? yes ___ no ___
Explain: _____

5. Are there any obvious personnel factors which deter from good patient care? yes ___ no ___
Explain: _____

6. Do personnel take advantage of all opportunities for postgraduate education or inservice training? yes ___ no ___
7. Is consulting/courtesy staff sufficient to provide all levels of consultation and assistance? yes ___ no ___

8. How is consulting staff utilized: Research _____ Teaching _____
 Ward Consultation _____ Other _____
9. Examine incident log on wards and central record room
- a) Are patient complaints promptly investigated? _____
 1. results noted in chart? _____
- b) Does the script receive daily incident reports on patients and employees? _____
- c) From the records, can trends pointing toward areas needing closer supervision be determined? _____
3. Psychiatric Services
1. Are patient histories adequate _____ complete _____
2. Do patients have appropriate routine psychiatric evaluation _____
3. Does medical director receive monthly reports on patient progress _____
4. Are complete records made on all tests rendered _____
 a) Are they filed with medical records _____
5. Do non-ambulatory patients receive appropriate physiological examinations? _____
 Tests? _____ Rehabilitation services? _____
6. Methods of psychotherapy uses:
 Psychoanalysis _____ Hypnotherapy _____
 Group Therapy _____ Interview therapy _____
 Re-education therapy and other _____
7. Number of patients receiving: Individual therapy _____
 Group therapy _____
8. Are all permits for shock therapy medically checked and approved?
 Yes _____ No _____ By whom _____
9. Shock therapy methods used: Metrazol _____
 Electric _____
 Insulin _____
10. Is shock technique careful and humane? Yes _____ No _____
 Muscle relaxing drug used? Yes _____ No _____
 Pre and post X-rays? Yes _____ No _____

11. Number of shock complications during 1962 _____
12. Are patients in restraint carefully protected _____
13. Describe condition of maximum security facilities _____
14. Are all orders for restraint and seclusion written and signed by a physician?
 Yes _____ No _____
15. Are they limited in regard to time? _____
 Appropriately reviewed? Yes _____ No _____
16. Are appropriate notes on special problems entered into medical records? _____
17. How often are untidy bed patients bathed _____
18. Are female patients well dressed _____
19. Are male patients well dressed _____
20. Describe special clothing used for disturbed/destructive patients _____
21. Are there adequate training programs for:
 a) psychiatric nurses yes _____ no _____
 b) psychiatric technicians yes _____ no _____
22. Do therapists display adequate knowledge and understanding of
 a) testing techniques yes _____ no _____
 b) interpretation of test indications yes _____ no _____
 c) patient safety factors yes _____ no _____
23. How much time does each staff member have available to devote to patient therapeutic activities? _____
 Nature of these activities _____
24. How much time does each patient spend (average) with a therapist?
 Group therapy _____ Recreational _____ Industrial _____
 How frequently? _____
25. Educational programs
 MD _____
 Psychologist _____

Social Worker _____
 Rehabilitation therapist _____
 Occupational therapists _____

26. Is relationship between medical staff and technicians
 Good _____ Fair _____ Poor _____
28. Does Psychologist
 a) hold staff conferences _____
 b) assist ward physician _____
 c) perform screening examinations _____
 d) conduct group therapy _____
29. How are social workers utilized?
 a) patients _____
 b) families _____
30. Ward activities
 a) self government _____
 b) OT assignments _____
 c) others _____
31. Impression of overall therapy and treatment program
 Occupational therapy _____
 Recreational therapy _____
 Physical therapy _____
 Group therapy _____
 Individual therapy _____
32. Is drug therapy program designed to meet individual patient needs?
 Yes _____ No _____
 How frequently are orders reviewed? _____

4. Medical -Surgical

1. Do the visiting and consulting staffs work closely with the resident staff?
 Yes _____ No _____
2. Are bylaws, rules and regulations
 a) clearly set forth in writing? Yes _____ No _____
 b) Enforced? Yes _____ No _____
3. Are privileges and duties of different staffs clearly defined?
 Yes _____ No _____

4. Are combined meetings of consulting and resident staff held?
 Yes _____ No _____ Frequency _____
5. Conference, meetings and minutes
 a) clinical Yes _____ No _____
 b) CPC Yes _____ No _____
 c) Staff Yes _____ No _____
 Are Minutes adequate (staff meetings) Yes _____ No _____
6. Are medical records written promptly and adequately? Yes _____ No _____
 Available on ward? Yes _____ No _____
 Signed by a physician: Yes _____ No _____
7. Staff committees
 Minutes of all committee meetings for the past 12 to 18 months should be examined. The following outline may be used as a guide:
 (Comment also on attendance of committee members at meetings.)
- A. Executive or Policy Committee:
 1. Provided for in bylaws/regulations? Yes _____ No _____
 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws? Yes _____ No _____
 3. Do other staff committees report to the Executive/Policy Committee or Superintendent in accordance with bylaws? Yes _____ No _____
 4. Are disciplinary matters adequately handled by the committee?
 Yes _____ No _____
 How many in past 12 months? _____
- B. Qualifications or Credentials Committee
 1. Provided for in bylaws/regulations? Yes _____ No _____
 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws? Yes _____ No _____
 3. Does Committee make continuing studies of all staff members.
 Yes _____ No _____
 4. Are annual recommendations made to the Executive Committee on reappointment of all staff members? yes _____ no _____

C. Joint Conference Committee

- 1. Provided for in bylaws/regulations? Yes _____ No _____
- 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws?
Yes _____ No _____
- 3. How many times has committee met in past 12 months? _____

D. Medical Records Committee

- 1. Provided for in bylaws/regulations? Yes _____ No _____
- 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws? Yes _____ No _____
- 3. From your observation, do the medical records on the wards and in the record room indicate that this committee is exerting its influence on the caliber of medical records? Yes _____ No _____

E. Tissue (Surgical Procedures) Committee

- 1. Provided for in bylaws/regulations? Yes _____ No _____
- 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws? Yes _____ No _____
- 3. Is the hospital pathologist a member or consultant to the Committee?
Yes _____ No _____
- 4. Is all tissue removed sent to pathologist? Yes _____ No _____
- 5. Review the surgical schedule record to learn what type of surgery is being done, by whom, and other pertinent matters.

F. Medical Procedures Committee

- 1. Provided for in bylaws/regulations? yes _____ no _____
- 2. Do minutes of meeting indicate that the committee is active and functioning in accordance with the staff bylaws?
yes _____ no _____
- 3. Review approximately twenty (20) cases of seriously ill patients from the medical department during the past six to nine months.

G. Review activities of sections such as O.B., pediatrics and GP to determine how control of individual members is being exercised.

H. Relationships within the Hospital.

- 1. How would you rate the morale of the medical staff with reference to:
 - a. Relationship with Medical Director _____
 - b. Relationship with Administrator _____
 - c. Relationship with each other _____
 - d. Relationship with the Nursing Staff _____

8. Is clinical laboratory equipped and professionally staffed for

- A. Chemical examination? yes _____ no _____
- B. Bacteriological examination? yes _____ no _____
- C. Pathological examination? yes _____ no _____
- D. Serological examination? yes _____ no _____
- E. Frozen section examination? yes _____ no _____

9. Are facilities for procurement, safe keeping and cross matching of blood adequate? yes _____ no _____

10. Radiology Department:

- A. Are proper safeguards provided for patient and personnel?
yes _____ no _____
- B. Are reports of interpretation in writing and signed by radiologist?
yes _____ no _____
- C. Is copy of radiologist report filed with patient's records?
yes _____ no _____

11. Is there a well qualified surgeon on the resident staff?

yes _____ no _____ Consulting staff? yes _____ no _____

12. What methods are used to prevent unnecessary and/or incompetent surgery?

13. Are surgical facilities adequate for

- General surgery yes _____ no _____
- Emergency yes _____ no _____
- Fracture yes _____ no _____
- Neurosurgery yes _____ no _____

14. Are assistant surgeons used in all appropriate operations?

yes _____ no _____

15. Are trained surgical nurses readily available? yes _____ no _____

16. Is equipment adequate? yes _____ no _____

comment (sterilization, lighting, etc.)

17. Is post-operative death rate within reasonable limits?

yes _____ no _____

18. Is consultation required in critical and/or obscure cases?

yes _____ no _____

19. Are the isolation facilities for obstetrical patients adequate?

yes _____ no _____

20. Is there a separate OB nursing staff? yes _____ no _____

are appropriate nursery techniques followed? yes _____ no _____
comment _____

21. Who administers anesthesia? _____

Qualifications: _____

22. Are adequate precautions taken re usual explosion and fire hazards?

yes _____ no _____

Comments _____

23. Is pharmacy well equipped? yes _____ no _____

24. Are narcotics properly controlled? yes _____ no _____

In absence of pharmacist? yes _____ no _____

25. Are appropriate wards or services under registered nurse supervision?

yes _____ no _____

26. Do nurses hold staff conferences? yes _____ no _____

27. Are nursing supplies readily available? yes _____ no _____

28. Are adequate clinical and ward records maintained by nurses?

yes _____ no _____

Technicians? yes _____ no _____

29. Do all newly admitted patients have dental examinations?

yes _____ no _____

30. Does staff include

- A. Dental assistant? yes _____ no _____
- B. Dental Hygienists? yes _____ no _____

31. Is dental equipment modern and well maintained? yes _____ no _____

32. What is the extent of dental work done?

Emergency _____
Restorative _____
Normal maintenance _____
Annual check-up _____