North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Dorothea Dix Hospital

820 S. Boylan Ave, Raleigh, NC

Michael F. Easley, Governor
Dempsey Benton, Secretary
Michael S. Lancaster, M.D. and
Leza Wainwright, Directors

James W. Osberg III, Ph.D.
Interim Hospital Director

September 19, 2008

Michael Lancaster, M.D.
James W. Osberg III, Ph.D.
Central Regional Hospital / Dorothea Dix Hospital

Gentlemen:

In our capacity as the elected officers of this Hospital's Medical-Psychological Staff, we are again writing you in your role as representatives of the Hospital's Governing Body. At a meeting of the Medical-Psychological staff yesterday, we reviewed the status of the Central Regional Hospital's readiness in light of the announced October 1-8 move of most adult patients from DDH to CRH. Once again, without dissent, the physicians and psychologists authorized us to send you this letter of concern.

We share with you the goal of – and responsibility for – providing high quality care to our patients. We appreciate that you incorporated some of the suggestions we made in our previous letter. Nevertheless, we believe that serious questions about safety and treatment programs remain. For the reasons summarized below, we urge postponement of the move.

The Central Regional Hospital has now operated for eight weeks with the staff and patients from John Umstead Hospital. There is still not a fully operational paging system or voice-over-internet phone system. Without a highly reliable paging system, physicians cannot reliably receive pages for urgent patient care, placing patients at unnecessary risk. The Code Blue/Duress alarms system continues to generate many false alarms, and there has not, to our knowledge, been a complete fire alarm/defend-in-place drill. We understand that physical repairs like a new antenna are planned, but they are not yet in place. The emergency response plan from CRH to the Child-Adolescent unit at JUH remains a matter of concern as well, and we question its adequacy.

A matter closely related to the safety and security of the buildings involves the adequacy of staffing. We are informed, for example, that the Forensic Maximum Security Male Unit (staffed at DDH with male health care technicians) will become staffed at CRH with a large number of female and male health care technicians from John Umstead hospital who have not worked in a forensic unit and have not yet received forensic training. The Forensic unit at Central Regional hospital has some very concerning design issues, including patient rooms with bathroom doors that do not lock, so access can not be restricted when necessary. There is no ability to restrict violent forensic patients from entering the nursing station and harming staff or property.

In addition, the Forensic staff at Dix has responded to "Pit Majors" (severe behavioral emergencies) throughout the hospital, including in the juvenile buildings. When Dorothea Dix closes, there will be a 60 bed overflow unit for CRH that will remain on the campus for at least one year and provide psychiatric hospitalization. The patients and staff in the child and youth buildings will also remain on the Dix campus for a few months during the renovations at John Umstead hospital. In our experience, the Forensic Service has provided critical support across the hospital when patients are

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acting in acutely dangerous ways. There is currently no plan in place for staff to respond appropriately to very dangerous patient behavior once the Forensic response team is moved to CRH.

A prominent feature of the CRH is the 60-bed satellite unit that will remain on the Dix Campus. Staffing plans for the "Dix Unit" remain tentative, so we rely on oral reports rather than written documents for many key characteristics. Currently, the physician at the unit is planned to be an internist, not a psychiatrist. When patients arrive overnight (as the often do), the patient would thus be initially examined for specialty mental health care, and admitted to a psychiatric hospital, by someone who does not have extensive training as a psychiatrist (e.g., four years of psychiatric residency training). This appears to be in violation of the proposed CRH credentialing and privileging manual, and departs from the standards of practice of the other North Carolina state psychiatric hospitals. It is also the most prominent example of plans (some in writing) to admit patients selectively to this unit so that only patients with less severe problems go to the Dix Unit, explicitly because this unit will have less staffing, medical equipment, and programming. This proposed unequal treatment for Dix Unit patients violates our understanding of JCAHO requirements for offering equivalent care to all patients, in addition to raising a number of EMTALA and other practical concerns that we can discuss with you at length.

From yesterday's press release, we learned that the decision to move forward was based, in part, on a consultant report from Dr. Lindsey and others from UNC Memorial Hospital. Dr. Wolfe called Dr. Lindsey, and was informed that the consultants visited the CRH facility before patients and staff were using the building. It may be prudent to ask them to re-visit the building when it is actually in use.

In our discussion yesterday, at least two major alternatives to the current plan emerged. One reasonable suggestion was to simply keep DDH patients at DDH (where we have working pagers and Code Blue systems) until the CRH building's phone/duress/fire alarm systems are demonstrated to be working consistently. Another suggestion was to simply move all DDH patients around the time that the renovations to the "new" child/adolescent facility (in JUH) are completed.

We will continue to work with you in a cooperative fashion as we move towards the final consolidation of JUH and DDH. However, our concerns about safety issues have compelled us to write this letter. Again, we urge you to reconsider the brisk pace of merger. We believe that, until these safety concerns have been fully corrected, that a move to Central Regional Hospital is premature.

Sincerely,

Nicole Wolfe, M.D.
President

Margaret Champion, M.D.
Secretary

Richard Rumer, Ph.D.
Joint Conference Representative

Cc: Ms. Wainwright
Secretary Benton