HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

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HOSPITAL INSPECTION
ITS IMPORTANCE TO THE CONSUMER

In the United States today, conditioned as we are by television's Marcus Welby and Medical Center, we think of our hospitals as life-saving institutions where hearts are transplanted and severed limbs reattached in a gleaming white atmosphere of futuristic sterilized technology. It is difficult for us to appreciate that not very long ago the term pest-house was synonmous with hospital and few patients expected to, or did, leave the premises alive.

This change in perspective is indeed related to fact. The modern hospital is often the setting for medical miracles, as well as a place where babies are born, tonsils and appendices are removed, and a wide variety of diseases are treated, most often successfully. This admirable record is maintained only by constant vigilance and rigorous adherence to standards. When these standards are relaxed the hospital is an ideal breeding ground for infection or disaster, since its patients are already weakened by the effects of illness. There are too many examples of miniature epidemics in hospital wards and nurseries, brought about by faulty or sloppy techniques, for any of us to be casual about the performance of our hospitals.

One of the ways in which a measure of control is exercised over the quality of a hospital is through licensing. Licensing is, by definition, a governmental process, which has the purpose of setting a minimum standard to which all licensed hospitals must adhere. Typically, the licensing agency prepares and reviews regulations, develops and carries out procedures for inspection of facilities covered by the law, and issues licenses to those facilities in substantial compliance with the law and regulations. Where the facility does not live up to the minimum standards, the agency should inform the violator of the deficiencies, supply expert consulting services to help remedy the lacks, and take proper steps to close the facility if no action to comply can be, or is, taken.

A hospital inspection is one important way to ensure that Federal, State, and local health standards are being met. In New York State, hospital inspectors review hospital structure, staff and facility. Some of the areas they review are:

1. The Medical Staff; the organization of the medical and dental staff; how their qualifications are determined, what arrangements they have for self-policing (tissue committees to reduce unnecessary surgery, reviews of all in-hospital deaths), functioning of the laboratory and other services (such as operating and recovery rooms), and special medical or surgical services (pediatric, psychiatric, etc.).
2. The Nursing Department; how the nurses' time is spent (bedside or clerical), control of medications, training and skill for special services (recovery room, operating room, etc.).
3. Social Service; is there qualified staff to meet the inpatient and ambulatory needs of the patient, how does the service function?
4. Dietary Service; the qualifications of the staff needed for preparation of special diets, as well as the physical facilities of the hospital kitchen (similar to restaurant inspection-with at least the same minimum attention to cleanliness and food contamination).
5. Hospital Administration; review the occupancy rates (a measure of efficiency in utilization of facilities), supervision of personnel (physical examinations required to prevent spread of diseases, such as tuberculosis, to weakened hospital patients).
6. Physical Plant; fire and safety (fireproofing, adequate egress, etc.), general sanitation, and environmental health (control of infection through adequate facilities for disposal of dirty linens, air circulation, etc.).

Statutory Requirement to Inspect

The New York State Health Department is required by Public Health Law to inspect all hospitals in the State, and the State Health Commissioner is legally responsible to watch over hospital performance. Chapter 795 of the New York State Public Health Law gives the Commissioner ". . . power to enquire into the operations of hospitals and conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel. . . (and) standards of care. . ." Article 28 requires the Commissioner to find the services and facilities fit and adequate before an operating certificate can be issued to a hospital. Operating certificates are

issued for a period of up to two years. A hospital cannot legally open or remain in operation without a certificate.

Until September, 1973, the New York City Health Department had the legal power to make full inspections of proprietary (for profit) hospitals and nursing homes in New York City. The State Health Department was responsible for inspecting all voluntary and municipal hospitals. City administrative procedures required each proprietary hospital to be inspected at least four times each year. These surveys, however, could not be considered comprehensive. Often these inspections were *unannounced*, or made at night or on weekends, which gave some assurance that the institution was not presenting a falsely favorable picture.

Effective September 1, 1973, however, a State law transferred the City's inspection responsibility to the State Health Department. In effect, the City was prevented from continuing its survey program. The City's proprietary hospital and nursing home inspectors were assigned to other duties and the State Health Department took over the responsibility for inspection of proprietary hospitals and nursing homes in New York City.

At that time, the State Health Department lacked personnel to perform adequate inspections. The State also had not inspected any voluntary hospitals in New York City for more than two years, in violation of Article 28. In spite of this personnel shortage, the State indicated its willingness and ability to perform the additional surveys of proprietary institutions in the City. The failure of the State to inspect hospitals was exposed in *A Comparison of Hospital Surveyors In New York State* CCAHS QUARTERLY, Winter, 1974.

Because the State was unable to perform complete inspections, temporary operating certificates were issued to all proprietary hospitals in September, 1973. These certificates expired January 31, 1974, but were automatically renewed. In October, 1973, the State Health Department performed limited spot surveys of proprietary hospitals and nursing homes in New York City. Verbal follow-up replaced the customary enforcement letter listing deficiencies, violations, and a request for a written timetable for corrections. Many deficiencies were corrected by careful follow-up.

State Survey Schedule Lags

There are approximately 123 voluntary, proprietary, and municipal hospitals in New York City. Between January 1, 1974, and September 1, 1974, the State Department of Health completed thirteen inspections of proprietary hospitals. Five more inspections (one voluntary and four proprietary hospitals), were almost complete, but the plans of deficiency correction from the institutions are not yet available. One additional inspection was started but not complete as of September 1, 1974. *At this rate of inspection it will take five or six years for the State Department of Health to inspect all New York City hospitals*, even if no follow-up inspections are made which can further delay re-inspection. Without aggressive follow-up, there can be no effective enforcement of standards or assurance that violations are corrected.

Safety Down - Costs Up

This lag in hospital inspection poses real problems for New York City health consumers. The most important, of course, lies in the danger that a hospital may pose to the health and safety of its patients. Few images are as frightening as that of a fire in a hospital, where bed-ridden patients may be unable to escape. But, if a hospital's physical plant is in violation of the fire codes, this danger is real and ever present.

There are documented instances in the United States of mini-epidemics in hospitals, some due to inadequate physical facilities which promote the spread of infection, and some due to personnel inadequately screened to eliminate carriers of diseases such as tuberculosis.

A second problem arises from lack of inspection when costs are added to the medical care bill by insufficient control of hospital operations. One measure of the adequacy of a hospital's operations is the level of occupancy. When the occupancy (rate) is not kept artificially high by admitting patients who do not need to be in the hospital, the occupancy rate can be a measure of how well the institution is utilized. The State Health Department has set a minimum sliding occupancy rate by type of service (i.e., 80% for medicine and surgical beds, 70% for pediatric beds and 60% for obstetrics-gynecology) as the point at which, it begins to withhold Medicaid funds as a penalty for underutilization of facilities. The effect of the establishment of this type of rate is to encourage hospitals to close underutilized services. Unfortunately, however, unless the need for admission is carefully monitored, hospital beds will be inappropriately filled, so that the hospital can avoid a penalty in its reimbursement rate. Without a constant program to audit and verify the statistical reports it receives, the State cannot know when sufficient numbers of a hospital's beds are remaining empty over a period of time in order to impose the legal fiscal sanctions. A survey or monitoring program that ensures the adequate review of occupancy (as a measure of utilization) and the clinical need of the patient to be admitted to a hospital (to prevent inappropriate use of hospital beds) is vitally needed.

Of the Article 28 surveys undertaken on or before September 20, 1974 by the State, at voluntary and proprietary hospitals the reports for Royal, Kew Gardens, Whitestone, Madison Avenue, Parsons, Astoria, Lefferts, Terrace Heights, Interboro, Midwood, Prospect and Boulevard Hospitals were complete and available to the public. The reports for Interboro, Midwood, Brooklyn Women's, Prospect and Boulevard Hospitals did not contain a Plan of Correction for the deficiencies (since the plans were not received by the Health Department within the deadline) and the survey for Wadsworth Hospital has been sent to the State Health Department Offices in Albany and is

not now available.

Recent disclosure laws (see *Freedom of Information—The Right of the Public to Know*, CCAHS HEALTH PERSPECTIVES, Vol. 1, No. 6, July-August, 1974) make the State Health Department survey reports of hospitals available to the public. A review of these reports performed by the State Health Department during the first nine months of 1974 reveals the existence of many serious deficiencies and violations.

Hospital surveys, if properly conducted and rigorously enforced, can be mutually beneficial to the public, the hospitals, and every patient.

Recommendations

The Consumer Commission recognizes the need to improve present hospital inspection surveys and enforcement. The Commission recommends that:

1. all hospitals in the City have *thorough, unannounced* Article 28 surveys no less than once every year, to be performed by a qualified team (i.e., physician, nurse, hospital administrator, and other health workers and consumers),
2. adequate follow-up inspections be made every three months, to ensure that violations and deficiencies are corrected, and that new violations are immediately identified.
3. the State or City Health Department expeditiously use due process to selectively close inefficient or unsafe services or deny licensure to those hospitals where major or uncorrectable deficiencies and violations pose a clear danger to patients,
4. there be full disclosure of inspection reports by the hospital to all medical and nursing staff, consumer advisory boards and community planning agencies,
5. that the full report be posted in the main lobby and other public areas of the hospital and printed in the local news media by the State,
6. the survey teams review occupancy rates and need for admission to prevent inappropriate use of expensive hospital beds,
7. adequate, qualified personnel be hired by the State (and City) to properly perform these inspections and subsequent enforcement, and
8. the State withhold Medicaid reimbursement to hospitals in an amount equal to the costs to improve facilities, purchase equipment or hire staff, and apply those withheld funds to the costs of correction of deficiencies.

Excerpts of State Health Department Survey Reports and Related Correspondence—*Brooklyn Women's and Kew Gardens Hospitals*

It is our purpose to show the kinds of problems and their potential dangers to consumers that may exist in hospitals in New York City. Some of the problems outlined in these official reports for Brooklyn Women's and Kew Gardens Hospitals have been corrected since the date of the survey. Unless periodic re-inspections are made and the findings reported, the public will not be aware of improvements or continued deficiencies at hospitals in the City.

The numbers listed in the inspection reports refer to the section of the New York State Hospital Code.

Brooklyn Women's Hospital

Mrs. Nat Gruskoff, President
Board of Trustees

July 8, 1974

Dear Mrs. Gruskoff:

Enclosed is a copy of the report of our Article 28 Survey conducted in May, 1974. The following is a summary of the major deficiencies noted in that report:

1. Nine graduate nurses were working without licenses or valid temporary permits.

2. The operating room was staffed with only one R.N. to cover all scheduled and emergency operations. There was no nursing supervisor in the operating rooms.

3. The kitchen is too small. Its walls, floors, windows and doors are worn, dirty and in poor repair.

4. The governing authority is not fulfilling its responsibilities to develop goals and policies for the hospital's operation and the quality of its care. Its committees are not functioning.

5. A current administrative policy and procedure manual does not exist.

6. The out-patient department is inadequate in space and facilities for the volume of services provided.

7. Medical staff committees are not meeting as required by your by-laws.

8. The occupancy of the hospital is below required levels.

Because of the seriousness of the deficiencies, we would like to discuss with you, and any other members of the Board you choose, as well as with the hospital administrator your plans for correcting the deficiencies.

Would you please call Dr. Carolyn Silbermann at 488-2728 within 10 days to make an appointment for such a meeting to be held in this office.

Sincerely yours,

Richard Nauen, M. D.
Associate Commissioner

cc: Mr. Lester Rubin, Administrator

Brooklyn Women's Hospital Inc. Article 28 Survey
Date of Survey: 5/14/74 5/20/74
Surveyor: Carolyn Silberman, M.D., Physician
Luz Halili, RN, Nursing Services Consultant
Betsy Strisower, Nutrition Services Consultant
Nasry Michelen, M.D., Sr. Hospital Administrator Consultant
Bruce Fage, Environmental Health Consultant
Madeline Penachio, Social Work Consultant

720.7 Admitting Department. . . . . .

The hospital has submitted a proposal to the State Department of Health for decertification of beds from 75 to 56. As noted above, even with a bed complement of 56, the Hospital has not been able to maintain the minimum occupancy level required for 80% and 60% for M & S [medicine & surgery] and Obstetrics respectively, It is recommended, to avoid future fiscal penalties because of low occupancy, that the institution consider reducing its bed capacity to 50. This will also help alleviate the overcrawdedness of patient rooms.

Our survey revealed the need for the following management improvements in the organizational structure:

1. The hospital has initiated a building program for the expansion of the facility which has run into financial difficulty, and that construction has been halted for about four years. It is recommended that the Governing Board constitute a long range planning committee which includes representatives of the hospital and the medical staff to determine in regard to expansion or limitation of the hospital's physical structure and the hospital's provision of services. It should also determine current status of its building program and difficulties encountered, and make appropriate recommendations to the Governing Board on course of action. In its considerations, this committee should take into account efficiency of present services, occupancy rate, and availability of related community resources.

Because the in-patient cost per patient of this hospital is considerably higher than those of like institutions of the same size and location ($136.79 as compared to $116.21) it is recommended that the hospital develop and implement administrative mechanisms for evaluating departmental performance as well as methods to measure cost, productivity and utilization.

As was suggested at the time of the survey, there appears to be a need for a full time qualified fiscal officer to establish and implement proper fiscal controls for the operation of the hospital. This step would also help relieve the administrator of this function and allow him more time to the general management and operation of the hospital, and for planning and policy formation and implementation.

There is a need for an operating and a capital budget, as recently mandated in the hospital code, Section 720.1. It is recommended that the institution initiate an approved operating budget, and a capital budget program for operational needs. . . . . .

Periodic reports should be also submitted by the Administrator to the Governing Board on the total operation of the hospital.

Physicians Report:

720.17 Emergency Department

A complete list of equipment and supplies available in the emergency room, indicating the location of each item or types of item should be available in the emergency service. Emergency medications should be stored so that they are easily identified and separated for easy accessibility when handling emergency patients.

720.18 Outpatient Department

The physical facilities of the outpatient department are thoroughly inadequate. The hospital is now providing approximately 20,000 outpatient visits a year and has only 2 examining rooms and no dressing rooms for these patients. There is also no space for nurse-patient conference. . . . . .

721.1 Medical Staff

The medical staff by-laws, rules and regulations must be updated. The last revision was in December 1970. The by-laws must provide for a Utilization Review Committee and for a Pharmacy and Therapeutic Committee.

The regulation providing for a screening uterine cytology smear on women 25 to 54 should be changed to comply with the present code requirement for women 21 years of age and over.

(q) 720.8 The regulations of the medical staff should provide for a blood grouping and Rh typing to be performed prior to admission of each patient to be admitted for an induced termination of pregnancy. If this is not practical, it must be performed prior to the termination of pregnancy.

The regulation should also provide for an evaluation of the need for Rh immune globulin and for its administration, if indicated. . . . . .

Medical staff committee meetings are not being held regularly as required in your by-laws. There are no minutes of the Tissue-Infections Control or Utilization Review Committee for the past four months. Tissue Committee minutes should record the number of cases reviewed, the number in which there was any disagreement between pre- and post-operative diagnosis and pathological report. . . . . If cases of hospital associated infections are discussed, these should be current cases. A lapse of seven months occured in some of the committee's discussion from the time of the patient's discharge. . . . . .

702.4 Infection Control and Reporting

The last recorded meeting of the infection control committee was 9/21/72. This committee should meet monthly to discuss and analyze problems facing the hospital involving infection control. An upgrading of existing procedures should be an ongoing function of this committee. . . . . .

712.2 Nursing Unit

1. Dayrooms are not provided on patient floors.
2. Other than hand controls are required on the medicine prep sink and the sink in the utility room.
3. The single-bedroom on each floor provided for isolation is equipped with a lavatory and shares a toilet room. No bathing facilities or anteroom provided.

   No isolation procedures were available to the surveyor. Definite procedures should be developed concerning the use of the shared toilet rooms when isolation cases are present.

   There are no grab bars for the toilet used for isolation cases.

712.6 and 720.13 Surgical Suite

1. Doors to the surgical suite are not kept closed.
2. There is no hygrometer to indicate whether the proper humidity is maintained.
3. The boot tester does not work.
4. There is no audible signal device to summon additional personnel from the O.R. supervisor's office or nurses workroom within the suite.
5. There are no doors to separate the soiled utility room from the operating rooms. There is a disposable curtain in one doorway, however, this is not adequate.
6. Drag chains are present on some equipment, these are difficult to keep clean.
7. Other than hand controls are needed on the sinks in the utility room.
8. The change areas should be located so that the staff may enter off the general corridor and discharge into the O.R. suite. . . . . .

712.10 Laboratory Suite

The morgue is not used for autopsies. It is used for storage of oxygen and miscellaneous combustibles. This storage should be cleared out.

The room contains a sink and a body refrigerator. No toilet is provided.

712.12 and 720.10 Dietary Departments

The kitchen is in very poor repair and in need of a good cleaning. The walls also need painting. The storage area can only be reached via an old, narrow, warped wooden stairway. The refrigerator boxes in this area are wooden with wooden shelving and therefore very difficult to maintain clean.

The ice machine in the pantry on the third floor of the hospital needs cleaning. There are also exposed overhead pipes in this pantry. . . . . .

720.10 Dietary Department

(b) (1) The Dietary Consultant spends approximately 2 hours per month at the hospital. Additional time is needed for patient charting and consulting with the food

service supervisor in the hospital.

(h) The space allotted the hospital kitchen is outside the building across the public street. All food is transported across the street to the hospital for serving to patients and employees.

The kitchen is inadequate; too small, the walls, floors, windows and doors all worn, dirty and in poor repair.

The food storage areas, both dry and cold, are inadequate. . . . . .

(m) Effective methods to assure proper cleanliness of equipment and utensils should be developed and maintained.

A new kitchen within the hospital is urgently needed.

720.8 Nursing Department

1. A nursing service master staffing plan was not available.
2. There were 3 different tables of organization, none of which reflected actual operational functions.
3. There was no documented evidence of any in-service and staff development program for all levels of nursing personnel.
4. A nursing service policy manual based on the general policies of the hospital and correlating all the functions of the nursing department needs to be expanded.
5. Some job descriptions need to be reviewed for updating and revision, e.g., the position description of the general supervisor did not indicate the [requirement] for the operating room supervisor that she be a graduate nurse with a current registration. Whereas the qualification required for a nursery head nurse was that in addition to New York State registration shw should have advanced preparation in unit management.
6. A nursing annual report for the preceeding year was not available.
7. Verified character references were not seen in 22 nursing personnel records that were reviewed.
8. Evaluation of the nursing care provided for patients will be done by means of a nursing audit. This has not been implemented yet, but the ground work has already been started.
9. Four foreign graduate nurses had expired temporary permits.
10. Five foreign graduate nurses had no license or temporary permit of any kind.
11. The Director of nurses has had no preparation beyond the diploma program. She has been Director of Nurses of this institution for the last 5 years and was Assistant Director of Nurses for 7 years before that.
12. Ward clerk positions were dropped as of March 12, 1974, due to this institution's financial difficulties.
13. Nursing care plans did not indicate short term and long term goals. There was no indication that the care plans were reviewed and assessed periodically. Nursing care plans should be developed for the medical and obstetrical patients.
14. The physician writes a summary report at the time of a patient's planned transfer. The registered professional nurse does not have any input into this.
15. Non-nursing functions that are part of the responsibility of the Director of nurses include:
    1. Supplying the floors with drugs
    2. Preparing the payroll every 2 weeks.

720.13 Operating Room

The operating room supervisor just resigned. She has not been replaced as yet. One RN. 2 LPNs. 2 Scrub Technicians. 1 orderly and 1 aide comprise the operating room nursing staff.

720.17 Emergency Department

A nursing supervisor is in charge of both the Emergency room and the clinic. A registered nurse works in the Emergency room under her direction on the day shift. The evening and night supervisors cover the Emergency room on their respective tours of duty.

722.1 Maternal Child Health and Newborn Services

1. There is no program of instruction conducted in the fundamentals of infant care or in the teaching of post-partum care, e.g., perennial care. The nurse or the physician informally gives instructions to each mother on the day of discharge.
2. Although the obstetrical unit and the Labor and Delivery rooms are closed units, supervision is done by this general day supervisor.
3. One room is designated both as the suspect nursery and the isolation nursery. Separate rooms are required.
4. Both nurseries were crowded and excess equipment should be removed.

Kew Gardens Hospital

Mr. Benedict L. Lurie, Administrator and The President of the Board — May 20, 1974

Dear Mr. Lurie:

Our Article 28 survey conducted on February 27 and 28, 1974 at Kew Gardens General Hospital revealed the following major deficiencies.

The By-Laws of the medical and dental staff require changes. These changes relate to:

Classification of appointments.

Assurance of adequate selection process of appointment to the medical staff.

Assurance of the nominating process of the Medical Board.

Adequate documents of the Credentials Committee.

Improvement of function of the Infection Control Committee.

Improvement of equipment in the laboratory.

Re-evaluation of the podiatry procedures and clinical supervision of the podiatrists.

Improvement of the totally inadequate and poorly equipped recovery room.

Serious consideration should be given to discontinuance of the pediatric service.

The department of Mental Hygiene will be advised as to concerns in the operation of a psychiatric service.

Nursing Department

Several areas of significant concern must be corrected among which are:

a. Performance of clerical duties by the professional staff.
b. Control of narcotics and barbiturates.
c. Improvement of medicine cabinets.
d. Poor emergency room availability.

Social Service

There is such limited social service as to make this critical element of patient care practically non-existent.

Dietary Department

The maintenance of acceptable standards of sanitation is seriously limited. This is an inadequate department.

Hospital Administration

There are several areas of concern, not the least of which is the confusion as to accuracy of occupancy rate.

Physical Plant

The deficiencies are all of such serious nature as to require attention of high priority to the complete report of the public

health sanitarian.

The above major deficiencies and the details of the attached reports must be given immediate attention.

Please send to this office within 30 days of the date of this letter a written plan and time table for the correction of these deficiencies, and your reaction to recommendations otherwise cited, noted for the attention of Leon R. Lezer, M.D., Associate Director.

Yours very truly,

Richard Nauen, M.D.
Associate Commissioner

Article 28 survey of February 27 and 28, 1974

752 By-Laws of the Medical and Dental Staff of Kew Gardens General Hospital

The classification of temporary appointments, provisional appointments, locum tenens appointments, emergency appointments need to be re-examined in the by-laws. This need arises from the fact that all of these classifications relate to a temporary appointment of one sort or another. The temporary appointment should be established as having a specific time limit, such as 30 days or 45 days, which ever may be appropriate according to experience at Kew Gardens Hospital. Since all of these appointments are of temporary nature it is not necessary to deal with them separately. It is important to deal with them in terms of a specific time for which an appointment shall be effective in order to permit scrutiny by the Credentials Committee, and by the Medical Board for continuing clinical privileges.

Article 10-Section III-Subsection 1

Subsection 1 states that each director of a clinical department or service shall be "the member of the active staff best qualified. . .". This subsection suggests that the director should be a person from within active staff who holds the highest attainment in this field, regardless of the possibility that the highest attainment may not be satisfactory as to expected accomplishment for the director of a service or a division in general hospital, such as Board certification, and the like. This subsection should be so worded as to eliminate the possibility of having the selection of a director of a department or a service come from only *within* the active staff of the hospital.

Subsection 2

This subsection seems to dictate to the governing body that it will, upon the recommendation of Medical Board, appoint such physicians or such directors as will have been recommended by the Medical Board. The language of subsection 2 should be so modified as to delineate clearly that final authority resides in the governing body with respect to appoints—and all other matters.

Article II-Subsection 1
Composition of the Medical Board

This subsection contains a statement that seems to ignore the responsibility of the Medical Board to *recommend* directors of departments to the governing body for their subsequent action. The sentence: "The directors of the departments shall be appointed by the governing body," should be modified in order to delineate clearly the responsibility of the Medical Board in recommendations to the governing body in such matters.

The Tissue Committee

It is noted that *The Tissue Committee* is now re-constituted as an active, standing committee of the medical staff according to the by-laws. This amendment was made as of January 1974.

The Credentials Committee. . . . . .

Recommendations of physicians cited in the application must be contained within the physician's file of the Credentials Committee.

It is not sufficient to state merely the names of physicians who would recommend. Actual letters of recommendation must appear in the physician's folder.

The Infection Control Committee

There should be evidence of routine cultures taken from areas cited in Section 7 of Article II of the by-laws. Culture reports should be on file within the laboratory.

Clinical Department

The clinical department meeting should clearly delineate by chart number, and by satisfactory entry, a review of *all* deaths. Satisfactory documentation of a review of all deaths should consist of at least a statement of discussion pertaining to causes of death as presented by the attending physician.

720.11 Laboratory

The laboratory has a commercial contract with Advance Medical Laboratories, 560 Northern Blvd. in Great Neck, Long Island. The Advance Medical Laboratories is a licensed and registered laboratory with certificate 4291. It expires June 30, 1974.

The laboratory, while under the supervision of competent pathologist, lacks adequate up-dated equipment in order to perform [satisfactory] procedures that the pathologist requires in the discharge of responsibilities to the hospital.

712.5 Psychiatry

The Psychiatry Department leaves so much to be desired as to lead to recommendation that the department of Mental Hygiene be so advised.

The service has a census of 35 patients representing total capacity which is usually maintained. The physicial plant and atmosphere is not adequate. It is considerably overcrowded, and there is a conspicuous lack of recreational facilities. Minimum use of social service, occupational therapy, and recreational activity is apparent.

Almost all patients receive electroshock in combination with chemotherapy. Electroshock today is considered a valid and effective treatment only for selected cases. Usually it is utilized as an emergency measure because of difficulty in controlling suicidal tendency, or in cases having shown themselves not to be responsive to chemotherapy and simple hospitalization.

Records reveal that 30 percent of patients who are first admissions for psychiatric disorder receive electroshock or chemotherapy. This is questionable practice.

In summation, the unit is not fuctioning as a modern multimodality inpatient psychiatric service which provides structure and a pleasant living [environment] and encourages appropriate high-quality, up-to-date ethical practice by all its attending physicians.

721.3 Pediatrics

Kew Gardens Hospital is in no way capable of handling pediatric patients. Last year's admissions totaled 12, two of which were tonsillectomies.

Facilities for pediatric patients do not exist which means that any child who is admitted will be placed in a room with adult patients. This is a traumatic experience for all concerned.

Since physical space, equipment and personnel are not pedi-

atric oriented, it is obvious to all, including the pediatricians on staff at Kew Gardens Hospital, that pediatrics should be eliminated from Kew Gardens Hospital.

721.6 and 752.4 Podiatry

The high incidence of podiatric surgery suggests careful evaluation.

While the By-Laws of the medical staff require careful supervision of podiatrists clinically, the record indicates a rather free opportunity for podiatrists to prescribe medications and rather elaborate treatment that should be countersigned by the attending physician. Within the frame work of the general hospital, there must be ample evidence of clinical supervision of the podiatrist's relationship to the patient. This includes the appropriate sequence of signatures on a patient's record in order to indicate clearly that the internist, for example, is supervisory in his relationship to the clinical activities of the podiatrist.

712.6 Recovery Room

The recovery room is totally inadequate and poorly equipped for careful supervision of patients. The nursing staff of the recovery room do not know how to defibrillate a patient, and are rather restricted in their professional competence for taking care of the most acute kinds of emergencies relating to cardiovascular collapse.

The recovery room should be properly equipped in order that each patient be satisfactorily monitored.

Anesthesia

The anesthesiologist is responsible for inhalation therapy. Inhalation therapy in appropriate measures should be made available on a decentralized basis throughout the hospital. Likewise, it seems prudent to have immediate availability of blood gas analyses in order to respond effectively to emergencies. The 48-hour relationship to a nearby hospital is not adequate in this regard.

720.20 Medical Records

All medical recordes must have a face sheet that identifies the patient, period of hospitalization, final diagnosis, complications, and surgical procedures performed, with a statement of condition upon discharge from the hospital. This face sheet must be signed by the attending physician. It is not adequate to have merely a signature of the attending physician upon the discharge summary only.

Accidents occuring to patients while in the hospital must be recorded as a part of the patient's hospital record in all instances. . . . . .

Miscellaneous

(a) There is an oversupply of narcotics and barbiturates on each nursing unit. Many of these drugs have not been ordered for any patient for months and should be returned to the pharmacy and be requisitioned in small quantities when they are needed.

(b) The medicine cabinets are located in small crowded dingy areas. Consideration should be given to the use of medication carts with individual drawers for each patient for the storage of all their medications. Medications could thus be administered at the bedside without being prepared in advance at the nursing station.

(c) The 35-bed psychiatric unit appeared to provide a very inadequate therapeutic milieu. An occupational therapist was employed for only a total of 9 hours per week. There was a total lack of decoration or color used to improve the stark atmosphere. After lunch, all the patients on the unit were herded into the sitting area where no provision was made for diversional activity. Nursing activity appeared to be geared mainly to administration of medications and assisting with treatments and the physical needs of the patients leaving little time for the nurse to contribute to the therapeutic milieu.

720.17 Emergency Department

The emergency room is locked. The medicine cabinets are also locked. The keys to these areas are kept separately. Once this area is opened, all the equipment should be readily available for use.

Report of the Public Health Sanitarian March 18, 1974

Nursing Units 712.2

Many patients room (multi-bed) do not meet minimum square footage requirements (80 sq. ft. per bed exclusive of toilet rooms, closets, lockers, wardrobes or vestibules).

Multi-bed rooms exceed two beds side by side parallel to the windows wall.

Some patient rooms are not provided with nurse call bells or reading lights (Section 3 East). Also, some toilets in this section do not have grab bars, and some showers are not provided with a call system.

Isolation rooms are inadequate in number (require one per 30 patients), and are not provided with ante-rooms with lavatory. (In addition to lavatory and separate toilet with bath or shower inside the isolation room). . . . . .

Psychiatric Unit 712.5

A minimum of 1/3 total bed compliment is required to be comprised of single-bed rooms. Also, maximum size of a psychiatric unit is limited to 32 beds (35 beds are present).

Insufficient space is available for the lounge, dining and recreational space. The lounge area requires a minimum of 25 sq. ft. per patient bed, the dining space a minimum of 15 sq. ft. per patient bed, and day room space at a ratio of 50 sq. ft. per patient bed subdivided into activity areas to reflect the treatment program of the unit.

An equipment storage room is not provided for the storage of recreational and occupational therapy equipment, nor was such equipment observed in this unit.

4. It is necessary that a patient bathroom designated for use by the physicially handicapped be provided.

5. It is necessary that the psychiatric unit provide "a non-institutional home-like atmosphere." This does not appear to be provided at this facility due to the above documented inadequate recreational and dining facilities, and lack of single-bedded room. . . . . .

Fire and Safety (NFPA 101-1967 edition)

The original building is non-fire resistant (ordinary protected) construction. The N.Y.S. Hospital Code and the Life Safety Code (NFPA 101) require that multi-story occupancies be of fire resistant construction (minimum of 2-hour rating) 10-1322.

Access to exits is via narrow passage ways of approximately 32". (Corridors leading to out side fire stairs). It is required that corridors required for exit access provide at least 96 inches in clear and unobstructed width. 10-1233

Alternate means of egress from 4 sections of this facility is via outside fire stairs, with access to them via the narrow corridors mentioned above. These fire escape stairs are not properly enclosed to protect them from adverse weather conditions, and are not in full conformity with NFPA requirements for such structure (treds are required to be solid, with ½" dia, perforations).

The east and west exit stairwells (interior) are not provided

with positive latching devices, and stairwell doors from both sides of the corridors leading to the stairs were observed held open at all floor levels. (These stair platforms constitute corridor egress between the two sections of the wings). 5-2133 stairwell doors must be kept closed at all times.

The main exit stair is improperly enclosed. It is open at the lobby level, and many doors at the upper level are not B-labled, 1½ hour rated fire doors. (The door to the medical record room have large *plain* glass panels; the door to the 2nd floor waiting room has excessive wired glass; and the doors leading to the central corridors are not positive latching).

Also, the medical records storage room located at the 4th floor level within this stairway is not sprinklered. (Sprinkler head blocked by partition) 10-1371

There are horizontal sliding doors separating the 1940 bldg. from the 1950 bldg. These doors are held open on fusible links. Swinging doors only, held open by magnetic hold open devices interconnected with the fire alarm, sprinkler system and smoke detectors are acceptable in horizontal exists. 5-5111 and 5-5143

The kitchen exhaust hood is not provided with automatic fire extinguishment. It is required that a system utilizing CO_2 dry chemical or fire water spray be provided, with automatic and manual release. 712.23 (5)

Openings in the corridor wall which enclose the emergency generator should be sealed to provide proper fire separation. 10-2351

The examination room in the East bldg. is small, and is partially occupied by an electrical closet, which would render the use of oxygen extremely hazardous.

Environmental Health

Biological and infections wastes are not destroyed on the premise by incineration. This Department must be informed in writing as to the method utilized for the destruction of these materials. 702.2

It is recommended that bacillus test spore (ampule) system be utilized in the central supply. This system provides accurate and fast method of determining effectiveness of the autoclave cycle. . . . . .

Surgical Suite

Documentation regarding the filtration efficiency of the O.R. mechanical ventillating system is required. (Two filter beds are necessary with the upstream filter having an efficiency rating of 30% and the down stream filter having an efficiency of 90% (Nat. Bureau of Standards Dust Spot Test) 712.23

720.10 Dietary Department

B.115 A review is indicated of the secondary supervisory level (contact dietitians) focusing attention on combining service procedures with the ultimate goal of staff reduction through attrition.

D2 The method of documentation of counselling provided, type of diet, by whom ordered, etc. needs updating.

K4 The pot washing procedure needs review.

H. Due to the limitations imposed by a poorly planned kitchen including storage and refrigeration areas it is impossible to maintain acceptable standards of sanitation in the dietary department.

Social Services

The department is functioning under an extremely limited arrangement. The qualified consultant has been absent for eight week[s], due to illness, and no attempt has been made to secure an interim replacement.

The present social work assistant continues on a schedule of two full days and one evening per week. While some noteworthy beginnings have been made, as in the preparation of an informational flyer for new admissions, the need for qualified consultation both to the program as a whole and to the assistant in individual case situations was evident.

There were no social work entries on medical charts at the time of our visit. The assistant would benefit from consultation as to the appropriate content of chart entries.

There has been no participation in inservice training to other disciplines.

No log of the consultant's activities was seen. A brief, summarized record of the nature and frequency of his visits should be maintained.

The dearth of referrals from psychiatry to social service department was noted. It would seem likely that at least some of these patients are in need of supportive services such as housekeeping or homemaking on return to the community.

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