North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Central Regional Hospital
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Michael F. Easley, Governor
Dempsey Benton, Secretary
Michael S. Lancaster, M.D., and
Leza Wainwright, Directors

Michael S. Lancaster, M.D.
Interim Hospital Director

September 23, 2008

Nicole Wolfe, MD
Margaret Champion, MD
Richard Rumer, PhD

Dr. Wolfe, Dr. Champion and Dr. Rumer:

I am writing in response to the Medical-Psychological staff letter dated September 19, 2008, citing concerns regarding the planned move of the Dorothea Dix Hospital (DDH) patients to the new Central Regional Hospital (CRH). I appreciate your concerns for the safety and well being of our patients and staff. As you noted, there have been, and will continue to be, improvements in the hospital safety, security, and treatment based on comments from many sources including our staff and patients.

The original plans were to move both hospitals to CRH at the same time. This was adjusted to move John Umstead Hospital (JUH) first to be followed by the move of DDH patients and staff. It is noted that we have been operating in CRH for eight weeks. While there are still areas we are actively addressing, we have made significant progress. In regard to the paging system, we have been assured by USA Mobility that the antenna they will install late this week will resolve "99%" of the pager access issues. There was a "fix" implemented for the duress system last week, and as we monitored the program over the weekend, the number of false duress signals decreased to less than two per shift. We will continue to monitor this process, but in addition we continue to have the overhead paging system in place to notify hospital wide of any duress event where assistance is needed.

In regard to your concerns about the forensic unit, I hope you are aware that there have been recent reviews of the space with forensic staff to identify the remaining issues that need to be addressed prior to occupation of the units. I fully expect that the issues noted will be addressed (as they have been on other PCUs) to the satisfaction of the staff. As you are aware, there are several issues that we have noted after the occupation of the space that we will address after the move. Training of the staff who have been identified as working on the forensic unit should have begun by the current forensic team. I will follow-up on that issue. While I am aware the practice at DDH has been for forensic health care technicians to be the primary responders to major behavioral events at DDH, it is my expectation that the staff on each unit at CRH and on contiguous units will be able to manage behavioral emergencies with the well trained staff available. This has been the longstanding practice at Broughton and Cherry Hospitals, as well as at JUH.

I am concerned that the discussion of the medical-psychological staff did not include issues that make remaining in DDH problematic, as I strongly believe there must be a balanced discussion. The difficulty in having staff assigned to both locations has become increasingly problematic. I have heard from the clinical leadership at DDH that there has been a significant impact on the treatment programs of both facilities as we remain apart. The staffing concerns continue to mount as we are not able to combine our staffs as planned, leaving gaps in both facilities to fill with agency and travel personnel. You note some of the concerns related to safety issues and fire drills in particular at CRH, but I am equally concerned that much of the currently occupied DDH residential space does not comply with modern building codes for even the most basic fire protection systems, such as sprinklers; most of Dix is not sprinkled at all (including the child units). The current average age of the fire alarm systems at DDH are significantly older (some built in the 1960s) than the CRH facility. The CRH fire alarm system is operating in accord with all current certification and code requirements. In addition the emergency power available at DDH is very limited in event of a power emergency. These are significant concerns about prolonging the occupation of these older buildings.

Other improvements in the new facility that must be acknowledged are the private rooms, the private bath rooms, the open space, and the courtyard settings. All of these aspects of the new hospital convey an increased level of respect and dignity for our patients. The current common bathrooms and congregate living settings at DDH do not support the privacy or dignity of the people we serve. The treatment mall program is not able to be completely functional in either location until staff are integrated, and the comprehensive programming envisioned can be made available. I feel it is critical that we weigh all of these issues and concerns as we make this decision on the timing to merge our hospitals.

In closing, I also want to express my concern as to the fashion this letter and the information it contained were conveyed to me. As you know, Dr.Wolfe, you and I were in a meeting all Friday afternoon until 5:30; during this time, this letter was not mentioned. The letter was faxed to my office on Friday afternoon at 4:00pm, while you and I were meeting. It appeared on a public list serv and a newspaper article before I saw the letter or even heard about it. The issues noted in this letter were discussed directly with the CRH medical staff on September 11; two of the signatories of this letter are members of that group and were in attendance at that meeting. During that discussion, there was no indication that the CRH medical staff felt that a letter needed to be written. I have asked Dr.Vance to address the medical staff at CRH to clarify their impressions in this regard.

I appreciate the opportunity to address these issues and would look forward to an open and complete dialogue as we move forward in the best interests of the patients we all serve.

Sincerely,

Michael Lancaster, MD

cc: Dempsey Benton
Leza Wainwright
James Osberg