U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

January 15, 2009

The Honorable Sonny Perdue
Office of the Governor
203 State Capital
Atlanta, Georgia 30334

Re: CRIPA Investigation of the Northwest Georgia Regional Hospital in Rome

Dear Governor Perdue:

I am writing to provide the Civil Rights Division's second report of findings regarding our investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness or developmental disabilities who are treated in public institutions. The findings discussed in this letter apply particularly to the Northwest Georgia Regional Hospital in Rome, Georgia ("NWGRH" or "Facility"). Our first report, dated May 30, 2008, concerned the Georgia Regional Hospital in Atlanta ("GRHA").[1]

On April 18, 2007, we notified you that we were initiating an investigation of conditions and practices in the State's Psychiatric Hospitals pursuant to CRIPA. The State agreed that the Department's inspection of four of the State's hospitals would stand as representative of all seven hospitals in the system. We began our on-site inspections with a visit to GRHA on September 17 through 21, 2007. The visit to NWGRH was on October 29 though November 2, 2007, and the visit to the Georgia Regional Hospital at Savannah occurred on December 17 through 21, 2007. The visit to Central State Hospital in

[1] We note that many, if not all, of the findings we make regarding NWGRH are representative of conditions encountered at the two other hospitals we have inspected to date, the Georgia Regional Hospitals at Atlanta and Savannah.

Milledgeville was postponed, and we have not yet been able to find a mutually agreeable date for that visit. According to our agreement with the State, these four hospitals would be representative of the remaining State Psychiatric Hospitals, including Southwestern State Hospital, East Central Regional Hospital, and West Central Regional Hospital.

We conducted our on-site review with the assistance of expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, and discharge planning and community placement. While on-site, we interviewed administrative staff, mental health care providers, and patients, and examined the physical plant conditions throughout most, but not all, of the Facility.[2] In addition to our on-site inspection of NWGRH, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and grave concerns about NWGRH to counsel, administrators and staff, and State officials.

In accordance with statutory requirements, we now write to advise you formally of the findings of our investigation

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[2] As we noted in our May 30 letter, the State, asserting that CRIPA does not afford jurisdiction over admissions, intake, and "short-term outpatient" units, refused us access to such units at each of the hospitals we have visited thus far. The State's position is incorrect. See, e.g., 42 C.F.R. § 483.20 (2006) (describing the State's duty to provide physician orders for immediate care at the time of admission and to perform comprehensive assessments within fourteen days of admission). By law, our investigation must proceed regardless of whether officials choose to cooperate fully. Indeed, when CRIPA was enacted, lawmakers considered the possibility that state and local officials might not cooperate in our federal investigations. See H.R. Conf. Rep. 96-897, at 12 (1980), reprinted in 1980 U.S.C.C.A.N. 832, 836. As we informed the State's attorneys, the State's decision to deny us access to these areas permits us to draw negative inferences about conditions and practices in those units. See id. While we did not need to draw negative inferences in making the findings described in this letter, we reiterate that we are authorized to do so if the State continues to deny us access to these areas in the future.

pertaining to NWGRH, the facts supporting them, and the minimum remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at NWGRH violate the constitutional and statutory rights of its patients. In particular, we find that NWGRH: (1) fails to adequately protect its patients from harm; (2) fails to provide appropriate mental health treatment; (3) fails to use seclusion and restraints appropriately; (4) fails to provide adequate medical care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XVIII and Title XIX of the Social Security Act, 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid); Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132-12134; 28 C.F.R. § 35.130(d); Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; see also Olmstead v. L.C., 527 U.S. 581 (1999).

As we noted when we wrote concerning GRHA, the majority of the findings we have made have also been made by other agencies in the past. See, e.g., Peter Buckley, M.D., and Nan Lewis, M.P.H., Medical College of Georgia, Audit Summary - Northwest Georgia Regional Hospital - Rome, September 26, 2007 (describing deficits in protection from harm, mental health treatment, nursing staffing, risk management, and performance improvement); United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Survey of Northwest Georgia Regional Hospital at Rome, March 3, 2004 ("CMS Survey") (describing failure to meet federal regulatory standards in protection from harm, individualized mental health treatment, use of seclusion and restraints, and nursing services). Throughout this letter, we have included specific references to past findings by these entities, where appropriate. We found that these same conditions remain unabated, despite NWGRH's notice of the deficiencies.

Nearly a decade ago, the United States Supreme Court made clear that the unnecessary institutionalization of persons with disabilities violates the law. Olmstead, 527 U.S. at 587. Olmstead involved two women with developmental disabilities and mental illness who were inappropriately confined at another of the State's Psychiatric Hospitals, GRHA. Id. at 593, 597. The Supreme Court held that states are required to provide mental health treatment to persons in the most integrated, appropriate settings. See id. at 596-97. In the wake of the Olmstead

decision, Georgia commissioned numerous studies of deficiencies in its community mental health care system, including: a February 2004 Study of the Community Service Board ("CSB") Service Delivery System (Phase I); a January 2005 Study of the CSB Service Delivery System (Phase II); and a May 2005 Georgia Mental Health System Gap Analysis. As stated in the Phase II Study by the State's Department of Audits and Accounts, these studies "point to accountability, oversight, management, and quality of care issues." The finding that Georgia's high hospitalization and readmission rates compared to national averages persist, and are "evidence of a lack of community based services," was reiterated in the June 2, 2008 Governor's Mental Health Service Delivery Commission's Progress Report. Despite the mandate by the Supreme Court and the subsequent clear analysis and recommendations in Georgia's own reports, as indicated herein, our review of discharge planning at NWGRH finds that Georgia still frequently fails to ensure that patients receive appropriate and sufficient services to enable them to live in the most integrated setting consistent with their needs, as required by federal law.

I. BACKGROUND

Northwest Georgia Regional Hospital in Rome, Georgia serves residents of the 23 counties of northwest Georgia who have mental illness, substance abuse issues, and developmental disabilities. At the time of our visit, NWGRH had approximately 280 patients. Inpatient units included acute and long-term adult psychiatric units, forensic units, and units for persons with developmental disabilities.[3] Approximately 100 patients reside on the developmental service units ("DSU"), which are the units for persons with developmental disabilities, approximately 70 patients reside on the forensic units, and the remainder reside on the adult mental health units. The Facility is located on a large campus that includes a number of additional programs not included in this review.

II. LEGAL STANDARDS

The Fourteenth Amendment due process clause requires state mental health care facilities to provide patients with "adequate food, shelter, clothing, and medical care," along with conditions

[3] We note that, as with GRHA, the combination of populations at NWGRH is unusual for a psychiatric hospital. Each population and the combination of these populations present unique health, safety, and treatment concerns.

of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training, including treatment, as may be reasonable in light of their constitutionally-based liberty interests. Youngberg, 457 U.S. at 315, 319, 322.

In order to secure these liberty interests, individualized treatment must be provided to give patients "a reasonable opportunity to be cured or to improve [their] mental condition." Donaldson v. O'Connor, 493 F.2d 507, 520 (5th Cir. 1974), vacated on other grounds, O'Connor v. Donaldson, 422 U.S. 563 (1975); D.W. v. Rogers, 113 F.3d 1214, 1217-18 (11th Cir. 1997) (holding that the constitutional right to psychiatric care and treatment is triggered by the State's physical confinement of an individual with mental illness; the court noted the holding of Fifth Circuit cases, including Donaldson, which are binding upon the Eleventh Circuit if decided before September 30, 1981); see also Wyatt v. Aderholt, 503 F.2d 1305, 1312 (5th Cir. 1974).

Treatment is not adequate if it "is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." Youngberg, 457 U.S. at 323. Patients have a due process right to have all major decisions regarding their treatment be made in accordance with the judgment of qualified professionals acting within professional standards. Griffith v. Ledbetter, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989).

In addition, patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16. States are also compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, it is not acceptable to rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188.

It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Id. at 1189. Seclusion and restraint should only be used as a last resort. Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980). Further, professional judgment should be exercised on a case-by-case basis regarding the most appropriate

setting in which individual patients should be placed. See, e.g., Thomas S., 902 F.2d at 254-55.

Additionally, patients in a psychiatric hospital have certain rights protected by federal statutory law. Specifically, the State must provide services and activities to patients at NWGRH that are consistent with Title XVIII and Title XIX of the Social Security Act and their implementing regulations. See 42 U.S.C. §§ 1395 to 1395b-10 and 1396 to 1396w-1; 42 C.F.R. §§ 482-483 (listing program requirements for participating in Medicare and Medicaid). Furthermore, the State must take reasonable steps to ensure that patients with limited English proficiency and sensory deficiencies are provided with meaningful access to programs and services. See Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-7; 45 C.F.R. § 80.3; Americans with Disabilities Act, 42 U.S.C. §§ 12132-12134.

Furthermore, Georgia must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d)("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); see Olmstead, 527 U.S. at 607 (holding that states are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities).

III. FINDINGS

Significant and wide-ranging deficiencies exist in NWGRH's provision of care. Certain conditions and services at NWGRH substantially depart from generally accepted professional standards and violate the constitutional and federal statutory rights of patients who reside there. In particular, we find that NWGRH: (1) fails to ensure the reasonable safety of its patients; (2) fails to provide adequate mental health treatment; (3) engages in the inappropriate use of seclusion and restraints;

(4) fails to provide adequate medical care; (5) fails to provide adequate services to populations with specialized needs; and (6) fails to provide adequate discharge planning to ensure placement in the most integrated setting. Many of these deficiencies stem from a system that does not have clear, specific standards of care or an adequate number of trained supervisory, professional, and direct care staff.

A. NWGRH Does Not Adequately Protect Patients From Harm

Patients at NWGRH have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. NWGRH fails to provide a living environment that complies with this constitutional mandate. Specifically, patients at NWGRH are subject to self-injurious behaviors that are not responded to appropriately, particularly suicide attempts, and to frequent patient assaults that often result in serious harm. The Facility's ability to address this harm is hampered by inadequate incident and risk management, including deficient investigative practices.

1. Incidents at NWGRH Are Serious and Recurring

Our review of the incidents at NWGRH revealed that they are serious, recurring, and frequently result in grave harm. We highlight two areas where the problems are particularly acute: suicide ideation and attempts and patient aggression.

a. Suicidal Ideation and Attempts Are Not Addressed Appropriately

A significant number of patients are admitted to NWGRH for stabilization and protection because of suicidal ideation or attempts. We found a troubling number of incidents in which NWGRH failed to recognize signs of suicide risk and failed to take appropriate action. The following incidents illustrate the grave harm that has resulted from these failures:

- M.U.[4] was transferred to NWGRH as an emergency involuntary admission on March 31, 2006, having refused to take her medications at a community-based residential services provider. Her admitting diagnosis was paranoid schizophrenia, and she also reportedly had a history of

[4] To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

auditory and visual hallucinations. Documentation from her admission indicates that she denied present hallucinations, but she also stated that she believed she was under investigation. The admitting documentation also indicates that she refused to answer whether she was suicidal. Nevertheless, NWGRH placed her on routine observation. She was moved to a unit that evening. The next day, during room checks, M.U. was withdrawn, and NWGRH staff found her sitting on the floor of her room, rocking back and forth. That evening, when the unit was taken outside, M.U. climbed a tree and attempted to hang herself with her shoelaces. When that was unsuccessful, she dove head first out of the tree and died on impact.

- S.T. was admitted to NWGRH in October 2006, and he was noted to have a history of self-mutilation and suicide attempts. On October 19, 2006, just two weeks after his admission, S.T. went into a bathroom without any staff present after a staff member had given him a razor for shaving. S.T. removed the blade from the razor and slit his throat from ear to ear, resulting in four deep lacerations. Notably, although S.P. was placed on one-to-one observation following the incident, he was not reassessed for his emotional stability or risk of harm, and no treatment or behavioral interventions were made or modified.

Our review also revealed a number of incidents in which NWGRH failed to take appropriate corrective actions after the risk of suicide became evident. These examples illustrate a failure to intervene adequately to prevent future incidents:

- M.P. has lived on the DSU since 2004 and has a history of depression. On May 4, 2007, a staff member asked M.P. about an injury on his head, and M.P. alleged that he had been pushed into the wall by another staff member, striking his head. NWGRH initiated an investigation, which concluded that the allegation could not be substantiated. During interviews conducted pursuant to the investigation, however, three staff members reported that M.P. had threatened to kill himself earlier that day and was hitting his head against the wall in the dining room and his bedroom. None of the three staff members reported the suicide threats or self-injurious behaviors before the investigation. Moreover, even though the investigation recommended that the staff be retrained on reporting of suicidal threats and self-injurious behaviors, no referral was made to M.P.'s interdisciplinary team to reassess his current suicide risk

and to implement changes in his treatment and behavior plans.

- On June 16, 2007, D.I. attempted to strangle herself and was rushed to the emergency room. We found no evidence that this suicide attempt was reported or reviewed as required by NWGRH and State policies and generally accepted professional standards. Nor could we find any evidence that an investigation was conducted of the incident or that any corrective actions were taken.

b. Patient Aggression Is Not Controlled

Patient aggression is not adequately controlled at NWGRH. We found numerous instances in which patient-on-patient assaults resulted in serious injury to the victim, including fractures, lacerations, and head wounds, as the following examples indicate:

- A patient attacked K.Z. on September 25, 2007, and K.Z. suffered a laceration on his forehead that required sutures to close. On September 5, 2007, just 20 days earlier, a patient attacked K.Z., resulting in a cut above K.Z.'s right eye that also required sutures.

- In another assault in September 2007, a patient attacked A.W., fracturing his nose.

- On August 31, 2007, M.E. fractured his finger during a fight with another patient.

- Also on August 31, 2007, S.K. needed sutures to repair his left eyelid after an assault by another patient.

- Similarly, on August 23, 2007, E.Y. required sutures to close a cut on his left eyelid due to an assault. Five months earlier, on April 9, 2007, a patient attacked E.Y., and he sustained cuts to his face that required sutures.

- On July 3, 2007, a patient attacked K.I., resulting in cuts and bruises on K.I.'s scalp and left eyebrow and hearing loss in his left ear.

- When being assaulted by another patient on May 3, 2007, P.L. suffered a cut to the back of his head that needed sutures.

- On April 29, 2007, a patient assaulted K.R., and K.R. needed sutures to close the cut on his lip.

- A patient pushed K.H. to the floor on March 10, 2007, and K.H. hit his head, necessitating stitches to close the wound.

- On October 28, 2006, a patient hit C.D., fracturing his jawbone bilaterally.

- L.F. needed sutures to close a large wound to his scalp following an assault by another patient on October 1, 2006.

These examples also demonstrate the disturbing patterns we found in the patient-on-patient assaults, including repeat victims and units where patient aggression is particularly uncontrolled. E.Y. was attacked in both April and August 2007, resulting in significant lacerations, and K.Z. was attacked twice in September 2007, suffering similar injuries. Moreover, the two attacks on K.Z. both occurred on Unit 410, the same unit on which A.W. was assaulted, also in the month of September 2007. The repeated and significant level of violence on the units suggests a fundamental failure to address the root causes of patients' aggression and demonstrates a failure to intervene adequately to prevent future incidents.

2. NWGRH Provides Inadequate Incident and Risk Management

To protect its patients in accordance with generally accepted professional standards, NWGRH should have in place an incident and risk management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur. An effective incident and risk management system depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions. NWGRH's policies and procedures indicate that NWGRH has developed incident and risk management protocols, including incident reporting protocols, that are consistent with generally accepted professional standards. Unfortunately, these protocols are not consistently implemented at NWGRH, and the actual incident and risk management system substantially departs from generally accepted professional standards. Specifically, NWGRH fails to report incidents in a consistent and timely fashion. Moreover, NWGRH fails to identify risks and to implement corrective actions, and performs inadequate investigations. As a result, patients are routinely exposed to actual and potential harm, as indicated previously.

a. Incident Reporting Is Incomplete and Untimely

The first necessary step to address harm like that at NWGRH is to ensure complete, accurate, and timely incident reporting. If incidents are not reported properly, NWGRH's ability to respond to harm or the potential for harm on both individual and systemic bases is significantly diminished. Our review found that incidents are frequently not reported in a timely manner and, in some instances, are never reported. These deficiencies expose NWGRH patients to harm, as the following examples demonstrate:

- D.J.'s attempted suicide, discussed above, was not reported or reviewed as required by NWGRH and State policies. As a result, no investigation was initiated and no corrective actions were implemented, increasing the likelihood that such an incident could recur.

- On September 9, 2007, a staff member noticed a large bruise on U.M.'s shoulder but did not report it, in violation of policy. Later that day, a second staff member noticed the bruise but did not report it, also violating policy. On the morning of September 10, 2007, a third staff member noticed the bruise but did not report it, violating reporting policies yet again. It was not until early in the afternoon of September 10, 2007, that a staff member noticed the bruise and reported it as required by policy. U.M. was diagnosed with a fractured left clavicle, and the investigation into the cause of the fracture revealed the three staff members' failure to report their observations.

- Our review of witness statements and progress notes dated August 10, 2007, revealed that O.N. had assaulted other patients every day for a week, but NWGRH's aggregate incident report data erroneously indicated that O.N. had not had an incident of aggression since May 14, 2007.

- On July 11, 2007, T.C. was allegedly unnecessarily and improperly restrained on the admissions unit. NWGRH did not report this incident to the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases ("MHDDAD") for five days, contrary to State policy.

- K.D., a patient with developmental disabilities, has a history of silent aspiration, dysphagia,[5] and "handmouthing," where she places her hands in her mouth as a soothing mechanism. At approximately 4:30 p.m. on April 14, 2007, K.D. began exhibiting signs that she was choking. These signs continued and became so severe that at 6:00 p.m., the physician ordered increased supervision, vital sign measurements every two hours, and restricted her diet to ice chips. It was not until shortly after 8:00 p.m., however, when K.D. began to cough and gag repeatedly, that a staff member reported to the nurse that at approximately 4:00 p.m., when K.D. was moved from her bed to her wheelchair, a few broken hair barrettes were observed on her sheets. K.D. was immediately sent to a local hospital for observation, and was readmitted to the local hospital twice over the following two days for aspiration pneumonia. X-rays revealed a metallic object in her gastric area, and at least two broken barrettes were removed during surgery. The failure to immediately report the broken barrettes on K.D.'s bed is troubling, especially given the level of harm suffered. More troubling, however, is that this incident was never reported as the ingestion of inedible objects, known as "pica," and was thus not included in the Facility's aggregate data on pica incidents. Moreover, a safety plan addressing this risk was not completed until June 2007, nearly two months after the incident took place.

- U.N. is a patient with a significant history of choking, aspiration, and pica. On February 10, 2007, a NWGRH staff member left U.N. unattended during breakfast. When the staff member returned, she noted that U.N. had food on his face, but the paper cup holding the food was missing. At 9 a.m., a nurse attempted to give U.N. his medications, but he repeatedly spit them out. When the nurse inquired whether U.N. had eaten his breakfast, the staff reported that he had not eaten well and spilled his tray. It was not until the nurse asked to see U.N.'s tray and inquired about the cup that the staff member reported that the cup was missing. U.N. was placed on close observation, and was eventually sent to the local hospital. After returning briefly to NWGRH, U.N. began vomiting and was returned to the hospital. NWGRH and the local hospital both concluded that U.N.'s symptoms were due to the ingestion of the cup.

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[5] Dysphagia is the medical term for difficulty in swallowing.

> The failure to report the missing cup immediately, given U.N.'s history of pica, placed him at significant risk of harm.

Without reliable and timely data regarding incidents and injuries, NWGRH is incapable of responding appropriately to prevent future harm. Moreover, NWGRH has repeatedly been put on notice of its failure to report incidents, and to report incidents in a timely manner, by the State itself. The State's own investigative findings and corrective action recommendations, made by MHDDAD, consistently note these failures, and yet they persist:

- On March 21, 2007, the State recommended that a staff member receive additional training on the reporting of incidents, and also receive counseling regarding her fears of retaliation if she reported incidents.

- On March 28, 2007, the State required NWGRH to submit a Plan of Correction describing the steps NWGRH would take to ensure that incidents are reported in a timely manner.

- On May 7, 2007, the State required NWGRH to submit a Corrective Action Plan describing the steps NWGRH would take to retrain staff members on reporting of critical incidents, and particularly allegations of abuse.

- On May 16, 2007, the State reported that an allegation of abuse was not reported promptly in violation of procedure. Because this allegation was not timely reported, procedures for immediately removing staff from client contact while an investigation was conducted were not followed.

- On May 31, 2007, the State reported that NWGRH staff failed to report a suicide threat.

- In an August 13, 2007, report, the State observed that allegations of physical abuse were not reported, and that when they were reported, it was not in a timely manner. According to the report: "This is a repeat recommendation to NWGRH. This issue was most recently noted as a concern by this investigator in a report dated June 22, 2007."

NWGRH's failure to report incidents and injuries in a consistent and timely manner, especially after it has been notified of this failure repeatedly by the State, substantially departs from generally accepted professional standards.

b. Risk of Harm Is Not Identified and Sufficient Preventive Actions Are Not Taken

Incident management focuses on the collection and aggregation of data that are meaningful to protect an individual from harm, while risk management focuses on identifying actual or potential harm from that data and taking timely action to prevent the harm from occurring or recurring. Generally accepted professional standards dictate that a facility's risk management program: (1) identify actual or potential risks of harm based on historical data, diagnoses, and co-occurring conditions; (2) develop timely and appropriate interventions designed to reduce or eliminate the risks of harm; and (3) monitor the efficacy of the interventions and modify them as necessary in response to further data. NWGRH's risk management program fails to meet these standards.

As an initial matter, NWGRH fails to identify actual or potential risks of harm through analysis of historical data. For example, more than half of NWGRH's patients identified as having pica behaviors in 2007 reside on one unit. In 2007, these six patients ingested batteries, buttons, paper clips, crayons, and cleaning fluid. These patients have been treated at the local hospital on at least four occasions after ingesting an inedible object. Despite the potential for harm, during our visit to this unit we observed that numerous objects, including objects similar to those ingested, were easily accessible to the patients. Most troubling, we observed one patient at risk for pica attempting to obtain an item that easily could have been swallowed.

NWGRH also fails to implement appropriate interventions and corrective actions in a timely manner, as demonstrated by the following examples:

- On August 3, 2007, S.Q. eloped from his unit and was later discovered outside another building on campus. His interdisciplinary team was assigned to address this issue, but no corrective action had been taken by the time of our tour on October 29, 2007, nearly three months later.

- On July 23, 2007, F.L. fell when a staff member attempted to transfer him to a wheelchair. We found no record that the staff member had been trained on proper transfer techniques as of October 29, 2007.

- On July 6, 2007, S.L. fell during a transfer from his wheelchair to the bathing trolley, but corrective actions

were not completed until September 11, 2007, more than two months later.

- On June 25, 2007, K.K. eloped from the same unit that S.Q. eloped from later in the summer. The unit leader was required to address the failures in supervision that permitted K.K. to elope and to ensure that all staff understood their supervisory responsibilities. These corrective actions were not recorded as complete until August 10, 2007, a week after K.K. eloped again, and a week after S.Q.'s elopement from the same unit.

The failure to identify patients at risk of harm and to complete corrective action plans in a timely manner jeopardizes NWGRH's ability to protect patients from harm, and is a substantial departure from generally accepted professional standards.

c. Investigative Practices Are Inadequate

Generally accepted professional standards dictate that facilities like NWGRH investigate serious incidents such as alleged abuse and neglect, serious injury, attempted suicide, and death. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures. The investigative report should set forth the evidence considered, including all interviews conducted and documents reviewed, and it should clearly state the conclusions reached and the reasons for those conclusions.

The investigative process at NWGRH substantially departs from these standards. We found instances in which serious incidents and injuries, including attempted suicide, were not investigated at all. In addition, we also found instances in which critical evidence was not collected or considered, significantly diminishing the quality of the investigations. Failing to collect and consider significant relevant information is a substantial departure from generally accepted professional standards in performing investigations. The following investigations each illustrate these failures:

- As previously discussed, U.M. suffered a fractured clavicle on September 9, 2007. The investigative report into this incident does not include critical relevant information. In particular, it does not include any account of the events

that may have led to this injury. Moreover, there is no evidence that the investigator questioned U.M. about his injury or how it occurred. Ultimately, the report never determines what caused U.M.'s fractured clavicle.

- After M.U.'s suicide, discussed previously, NWGRH undertook a Root Cause Analysis ("RCA") to determine whether any measures could have been taken to prevent it. The RCA concluded that all policies and procedures had been followed, and staffing ratios were sufficient. The RCA bases this conclusion, in part, on its finding that neither the admitting hospital nor M.U. herself clearly indicated her suicidal ideation. The RCA does not appear to consider, however, that M.U. was admitted under the code for "Dangerous to Self Due to Mental Illness," and that this was the reason for her involuntary admission to the hospital and NWGRH. This status suggests that significant precautions should have been, but were not, taken.

- On February 2, 2007, N.L. alleged that she was struck by a staff member. There is no evidence in the investigative report, however, indicating that N.L. was examined by a nurse or other medical professional to determine whether she had an injury consistent with her allegation. Without considering this potentially critical evidence, the report instead concludes that the allegation could not be substantiated based on the staff member's denial and the supporting statement of another staff member.

Our review of the investigation into N.L.'s abuse allegation also revealed other troubling practices that substantially depart from generally accepted professional standards, and these practices unfortunately characterized other investigations we reviewed at NWGRH as well. First, the investigative process was not initiated in a timely manner. Although the alleged abuse occurred on February 2, 2007, the investigation did not commence until February 15, 2007, nearly two weeks later. The failure to investigate promptly impairs the collection and preservation of evidence and delays the implementation of corrective action that may prevent future harm. Second, the investigation included certain inconsistencies that raise doubts about its accuracy and thoroughness. The investigative report is dated February 21, 2007, but it includes a staff interview that is stated as having occurred on March 1, 2007. It is troubling that an apparently relevant staff interview may not have been conducted until after the report's conclusions were already reached.

B. Mental Health Care Is Inadequate

NWGRH patients have a constitutional right to receive adequate mental health treatment. Donaldson, 493 F.2d at 520. The mental health services at NWGRH, however, substantially depart from generally accepted professional standards. Psychiatric practices are marked by inadequate assessments and diagnoses, which in turn, lead to inadequate treatment planning and delivery of inadequate treatments and interventions. Contrary to generally accepted professional standards, treatment planning is not person-centered, individualized, or integrated across disciplines. Psychology services, physical, nutritional and speech therapy, and behavioral management services are particularly deficient. Medication practices and emergency services are inadequate. Each of these failures affects the quality and effectiveness of the patients' treatment plans, which are the foundation of an adequate mental health care program. Many of these deficiencies directly threaten patients' physical health and well being as well. Moreover, as was also the case at GRHA, NWGRH's failure to treat a patient's mental health needs while hospitalized has frequently led to failed discharges and to repeated hospitalizations.

In accordance with generally accepted professional standards, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. Treatment plans should define the goals of treatment, the interventions to be used in achieving these goals, and the manner in which staff are to coordinate treatment. The treatment plans should also detail an integrated plan designed to promote the patient's stabilization and/or rehabilitation so that the patient may return to the community. Taken together, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are critical to a hospital's ongoing efforts at quality improvement.

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable, and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the

treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

NWGRH treatment planning substantially departs from these standards. From initial diagnosis and assessment to the development of skills and functioning necessary for recovery and community reintegration, NWGRH's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; and patients are at increased risk of relapses and repeat hospitalizations. Further, patients' options for discharge are significantly limited, resulting in unnecessarily prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

1. Psychiatric Assessments and Diagnoses Are Inadequate

Mental health treatment begins at the time of admission. An admissions work-up is an integral part of the course of hospitalization; it establishes the initial diagnosis and begins the course of treatment for patients as they begin their hospital stay. We noted many deficiencies in the initial assessments we reviewed. Assessments were often not timely or thorough. Fatal harm can result from a failed assessment: M.U., discussed previously, received no suicide risk assessment before being given access to a courtyard area where she killed herself.

An effective treatment plan begins with a diagnosis that is clinically justified. If mental health professionals do not correctly identify a patient's psychiatric condition before developing a treatment plan, the treatment interventions will not be aligned with the patient's needs. Thorough assessments are necessary to identify presenting problems and strengths and needs of the patient, and to identify potential risks from aggressive or self-injurious behavior, potential victimization, substance abuse, or certain medical conditions. Adequate assessments are essential to the development of a person-centered plan that can direct rehabilitation, treatment, and care while the patient resides in the hospital, and to formulate an adequate discharge and transition plan for the patient's return to the community. Psychiatry, medicine, nursing, psychology, and social work should

each contribute to the assessment in accord with generally accepted professional standards.

At a minimum, an initial assessment should include: (1) an adequate review of presenting symptoms and the patient's mental status; (2) a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the patient and others. As more information becomes available, the assessment must be updated to include: (1) a history of the presenting symptoms from the patient based on the patient's level of functioning and from collateral sources, as available; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's biopsychosocial functioning; (4) a review and critical examination of diagnostic conclusions made in the past in light of new information; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

In many cases, initial assessments at NWGRH are incomplete. The majority of records reviewed at NWGRH lack assessments of social, vocational, functional, educational, and independent living skills. They also uniformly fail to assess history of community living and prior placements. These inadequacies are especially troubling for patients with a history of failed discharges and frequent re-admissions. Each of these deficiencies in assessment creates a serious impediment to the treatment team's ability to identify the services and supports a patient may need while in the Facility and upon discharge. An example of inadequate assessments includes:

- E.G., who has a diagnosis of schizoaffective disorder and mild mental retardation, resided at NWGRH from April through August 2007. Eighteen previous placements in different foster homes were disrupted by her aggressive behaviors. NWGRH did not perform a functional assessment to identify possible reasons for these behaviors or to develop a behavioral plan. E.G. received 31 PRN[6] medications during this admission, with one only two days before her discharge, and continued to have incidents of aggression and property destruction. Her treatment plan was not adjusted to address

[6] PRN, or pro re nata, medications are dispensed on an "as needed" basis.

her aggressive behavior. Thus, one of the primary problems presented at admission – E.G.'s aggressive and maladaptive behavior – was not assessed, not treated, and appeared not to be resolved at discharge.

NWGRH patients are routinely given tentative and unspecified diagnoses (including "rule out" and "not otherwise specified" ("NOS") diagnoses) as a result of these flawed assessments. We found virtually no evidence of further assessments or observations to finalize the diagnoses. Because different psychiatric conditions can have similar signs and symptoms, it is important for mental health professionals to address NOS diagnoses to ensure that a patient's treatment is appropriate for his or her actual mental health needs. At NWGRH, however, NOS diagnoses persist for months and over multiple admissions, with no sign of further diagnostic testing or refinement. The prevalent use of the "NOS" diagnosis reflects an inadequate diagnostic evaluation process and contributes to the lack of specificity in treatment plans. For example:

- N.Y. has had numerous diagnoses over the course of 16 admissions, and his stays are characterized by frequent agitation and clinical instability. There is no evidence that the Facility conducted psychological testing to clarify his diagnosis and, thus, target treatments more effectively.

- K.R. has a diagnosis of psychosis NOS, and her treatment has not changed significantly over the course of more than 50 admissions.

NWGRH's failures in the preliminary stages of assessment and diagnosis, as well as its failure to reassess patients to refine diagnoses, substantially depart from generally accepted professional standards. Patients receive or are at risk of receiving treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses. The result is that the actual mental illness is often unaddressed, placing patients at risk of prolonged institutionalization and/or repeated admissions to the Facility.

2. Treatment Planning Is Inadequate

a. Treatment Plans Are Not Individualized or Patient Centered and Do Not Address Patients' Needs

Treatment plans, which at NWGRH are called Individual Recovery Plans ("IRP") or Individual Habilitation Plans ("IHP"), are, for the most part, inadequate and fall far short of

generally accepted professional standards. They are frequently minimalist, generic, and reflect neither the true scope of patients' needs nor an integrated, coherent plan for treatment. Surveys by the Centers for Medicare and Medicaid Services documented incomplete assessments that result in incomplete and generic treatment interventions. See e.g., March 3, 2004 CMS Survey (treatment plans for 11 of 11 patients lacked comprehensive and individualized interventions). When the treatment team fails to identify or address all of a patient's presenting concerns, that patient is deprived of treatment for those concerns, and frequently subject to a longer period of institutionalization or to a repeat admission when those conditions or behaviors become barriers to successful community integration. Even worse, treatment plans at NWGRH often reflect contradictory plans of care. Treatment plans do not reflect interdisciplinary planning and corroboration, and contradictory assessments from different disciplines are neither addressed nor reconciled. Examples of deficient IRPs include:

- K.J. was re-admitted in July of 2007, one month after his last discharge. His diagnoses included depressive disorder and cocaine dependence. He received no treatment for substance abuse while in the Facility, and no referral to substance abuse services in the community. He was homeless at the time of this admission, and was discharged to a hotel.

- T.C., on her 44th admission to NWGRH, had been at the Facility for six weeks at the time of our visit. She had not participated in any active treatment, and had not been referred for a behavioral assessment, yet received PRN medications for disruptive behavior 13 times in a month.

- M.L. has a diagnosis of depressive disorder and anxiety disorder and was receiving two psychotropic medications, Buspar and Lexapro, presumably to address these disorders, yet his behavioral support plan ("BSP") does not address any behaviors or symptoms associated with depression or anxiety.

- F.C.'s communication assessment notes that he is considered "nonverbal," yet his behavior plan suggests that he "request social attention by speaking to others."

- K.I.'s annual communication assessment recommended no formal communication training; at the same time, his behavioral assessment found that his challenging behaviors served to elicit attention and gain access to desired activities, which are maladaptive means of communicating.

As discussed supra, Section III.B.1, inadequate assessments that fail to discern the reasons for multiple re-admissions, and treatment plans that fail to address relevant clinical presentations in a specific, individualized, strengths-based, and recovery-oriented manner have resulted in repeated failures of treatment at NWGRH and the subsequent failure to succeed in the community. Multiple re-admissions are extraordinarily costly to patients and the system. Frequent relapses may cause a progressive worsening of a patient's mental illness and make the patient more intractable to treatment. Multiple re-admissions are also costly to the system of care, resulting in multiple assessments, care plans, and other treatments, where one adequate provision of these services would have sufficed.

Treatment plans at NWGRH often provide no clear alternatives if the initial, vague interventions prove ineffective, leaving staff with few alternatives to restraint, seclusion, and PRN medications to address challenging behaviors. We typically found generic treatment objectives for patients with psychotic diagnoses and substance abuse diagnoses. The recurrence of near-identical goals and objectives for so many patients makes evident the non-individualized nature of NWGRH's treatment plans.

NWGRH does not provide sufficient treatment programming to patients, as noted by the State's own audit, which found "a fair amount of patient inactivity and sleeping on the units." NWGRH also fails to intervene when patients do not participate in even the limited number of treatment groups available. For example:

- F.O. attended none of the 35 groups scheduled in one week; his treatment team took no notice.

- B.T. attended no activities according to his QMRP quarterly review, although he was credited with 100% attendance and engagement levels, contradictory findings that apparently were not challenged by his treatment team.

- T.C., noted above, did not participate in active treatment for the first six weeks of her current admission, which was her 44th.

The lack of meaningful treatment and habilitation services for patients on the DSU, where the majority of the patients may need behavioral supports, is particularly problematic. A sense of staff complacency pervades the DSU, where patients' limited skills or challenging behaviors seemingly are accepted by staff as unchangeable, and is reflected in the inadequate treatment

plans and interventions for the patients of these units. For example:

- N.C.'s person-centered planning meeting was held without her, even though N.C. is described as a "very effective communicator via verbal productions" with excellent receptive language skills. The record also shows no participation by any family member, advocate, guardian, or direct care staff who knows N.C.

- None of T.M.'s training goals are related to the choices identified in her ISP, which is not surprising, given that neither T.M. nor any direct care staff participated in her person-centered planning meeting.

- K.I.'s plan includes only two training goals: one, within two years to be able to point to his pill and state its purpose; and two, within three years to fill out a mock check. The expectation of such slow and limited progress indicates unreasonably low expectations for K.I. Moreover, this plan ignores K.I.'s clear need for communication training to provide appropriate ways to express his preferences. His behavioral assessment hypothesizes that his challenging behaviors are associated with attempts to access preferred activities, that is, to communicate what he'd like to do.

The State's own audit also noted a concern with low hours of active treatment and patient interaction on the DSU. NWGRH's failure to provide adequate treatment to DSU patients is exacerbated by clinically outdated and unsupportable opinions about patients with developmental disabilities. For example, G.L.'s diagnoses include "behavior problems secondary to mental retardation." To conclude that challenging behaviors are an inherent and unchangeable part of the condition of mental retardation is a gross deviation from generally accepted professional standards, and suggests a lack of training and competency regarding current practices. Because of this commonly-held view at NWGRH, these behaviors are not addressed, patients are deprived of effective treatment, and these behaviors become a justification for continued institutionalization. This is an egregious violation of these patients' rights.

b. Failure to Address Repeated Admissions

High rates of re-admission at the Georgia Regional Hospitals are well documented. Audits commissioned by the Governor, including the 2005 Georgia Mental Health Gap Analysis study,

concluded that a 30-day readmission rate 55 percent greater than the national average contributed to overburdening the State's Psychiatric Hospitals. These conditions persist.

The work of admitting patients and providing the crisis stabilization necessary for new admissions leaves an already overburdened system with fewer staff resources to provide treatment planning, interventions, and supervision for patients. Moreover, frequent re-admissions are extremely detrimental to these individual patients, disrupting their recoveries and their lives in the community. Frequent relapses and re-admissions may progressively worsen a patient's serious and persistent mental illness and make patients more intractable to treatment. Thus, generally accepted professional standards demand that treatment teams routinely examine and address issues that cause patients to be admitted repeatedly to the hospital. However, in multiple cases of repeated admissions, we saw no evidence that the treatment team examined or addressed the factors that led to re-admission and altered the patient's treatment from a previous stay at the hospital. For example:

- K.T. was admitted for the fourth time on October 27, 2007, and was discharged, still grossly psychotic, two days later. His previous admission was just a month earlier, when he was discharged after just three days to a homeless shelter. At the time of that third admission, his team expressed the "hope" of identifying permanent housing such as a group home. But he was nonetheless discharged to a shelter without the supports of a group home, an unsuitable discharge that led to his fourth admission.

- K.J., discussed above, was also re-admitted within one month of his prior discharge. Despite diagnoses of depressive disorder and cocaine dependence, he received no treatment for substance abuse while institutionalized, and no referral to substance abuse services in the community.

- T.C., on her 44th admission to NWGRH, had not participated in any active treatment, and had not been referred for a behavioral assessment six weeks into her current hospitalization, despite frequent episodes of disruptive behavior and resulting restraint and administration of PRN medications.

- N.Y. was hospitalized for the 7th time in 2007 alone, yet his files contained no clinical information from prior hospitalizations to guide the team in understanding the

course of his illness and possible reasons for his repeated admissions.

c. Treatment for Substance Abuse Is Inadequate

There is a stark lack of treatment for patients with co-occurring diagnoses of substance abuse. It was evident in a significant number of records that this issue was one of the most serious impediments to community placement and part of the reason for frequent re-admissions to the hospital. In addition to lack of treatment in the Facility, we did not find a single referral for community substance abuse treatment in the discharge plans we reviewed for patients with a substance abuse problem. Among the more egregious examples were:

- N.T., with diagnoses of schizoaffective disorder and opiate dependence, reported using heroin for the past nine months. She was discharged following her 19th admission to the home of a family friend.

- K.U., with diagnoses of psychotic disorder, mood disorder, alcohol dependence, cocaine dependence, opiate abuse, and alcohol withdrawal, reported that he lived in an environment that was "drug infested." He was nonetheless discharged after ten days with no connection to substance abuse treatment.

The lack of substance abuse programming and its deleterious effects on patients at NWGRH is well known to hospital and State administrators. CMS cited NWGRH on February 7, 2007, for failing to provide adequate discharge planning in the case of a patient discharged with a bus ticket, a boxed lunch, and the address of an out-of-state shelter, but no provision for follow-up psychiatric care or substance abuse programming. We found numerous instances of similarly deficient discharge planning in our visit more than eight months later. In a pattern that echoes the failure of accountability throughout this system, the Facility's Chief of Social Work was unfamiliar with the plan of correction submitted to CMS that promised monthly audits of discharge plans overseen by the Chief of Social Work.

3. Behavioral Management Services Are Inadequate

a. Behavioral Services Are Not Timely

Behavioral support plans ("BSPs") at NWGRH are largely nonexistent, and those that exist are largely inadequate and not well integrated into overall treatment. Many patients who were

repeatedly subject to seclusion, restraint, and/or administration of PRN medications – measures that should be reserved for emergency crisis intervention – have no behavioral supports in place. This is an egregious departure from generally accepted professional standards. Routinely, even when a treatment team makes a recommendation for a BSP, these plans are not developed and implemented in a timely manner. Examples of failure to provide, or of inordinate delay in providing behavior management services include:

- N.Y., on his 7th admission in 2007, was subject to repeated PRNs and restraint, but had no behavior supports consistently in place.

- K.Q., whose challenging behaviors include rectal digging, aggression, and agitated movement (which his treatment team characterizes as "buck dancing"), waited nine months from referral to approval of a BSP.

- O.N., whose challenging behaviors include self-injury and physical and verbal aggression, showed marked increases in problematic behaviors in May, June, and August 2007, while his BSP remained "under development." The BSP had not been implemented by the time of our tour in late October.

- T.C. received multiple PRN medications and restraints due to agitation and aggression over a six-week period, but attended no active treatment and received no counseling; at the time of our tour, she had not been referred for an individual behavioral intervention.

- Q.M.'s treatment notes indicate that she does not understand her treatment and is confused and disorganized. She had received frequent PRNs during her year-long hospitalization, yet the hospital had not provided her with a functional assessment or behavioral treatment plan. We saw no evidence that her treatment plan had been adjusted despite her poor response to the current plan.

- D.D. was administered emergency medications at least nine times during the four months he waited for NWGRH to develop a BSP.

- A behavior specialist prepared a BSP for G.L. in May 2006, but it was not approved and implemented for more than five months. During this wait, G.L. continued to harm himself frequently.

- K.C. was admitted in January 2007, in part, because of unmanageable behaviors at home. While at the Facility, he continued to engage in self-injurious behaviors and physical aggression, behaviors that were noted by his treatment team in its monthly reviews. Despite continued maladaptive behaviors, and significant spikes in these behaviors in May and August, no behavior support plan was developed for more than nine months.

b. Behavioral Plans Are Not Modified Appropriately

For those few patients with behavioral management plans, treatment teams routinely fail to revise those plans, notwithstanding evidence of continuing or escalating problem behaviors. For example:

- G.L., whose BSP was delayed for more than five months in 2006, continued to engage in self-injurious behavior frequently in during the first quarter of 2007. Nonetheless, his QMRP Quarterly review for that quarter recommended "[n]o changes at this time." His substantially increased aggression and episodes of taking others' food in the following quarter drew the same response from his team: "Continues current programing . . . [N]o changes at this time."

- K.Y. showed an onset of physical aggression and increased verbal aggression in the first two quarters of 2006, yet his BSP was not revised; his current BSP states that he "has displayed neither maladaptive behaviors nor depressive or psychotic symptoms since his admission . . .," an assertion clearly inconsistent with this record.

NWGRH has too few skilled psychologists and behavioral specialists on staff to develop and monitor adequate behavior management plans for the many patients whose behaviors suggest a compelling need for such plans. At the time of our visit, the Chief of Psychology's caseload included 110 patients on the mental health units, plus 105 patients on the DSU. Generally accepted professional standards would require at least five more psychologists to service these units. Two forensic psychologists were responsible for 67 forensic patients and all necessary court evaluations. A total of six behavior specialists were also assigned to the units. Generally accepted professional standards require the work of the behavior specialists to be supervised by a doctoral-level psychologist – adding to the psychologists' already-impossible workload.

c. Behavioral Plans Substantially Depart From Generally Accepted Professional Standards

The few behavioral assessments in place at NWGRH substantially depart from generally accepted professional standards. In some cases, patients with behavior plans had no functional assessments of the problematic behaviors to support the behavior plan. In others, the functional analysis was deficient in one or more significant ways: many failed to hypothesize the function of the challenging behavior; did not consider antecedent, environmental, or health factors that influence a behavior; did not contain sufficient baseline data; failed to identify target or replacement behaviors; and suggested inappropriate and even dangerous replacement behaviors. These inadequacies in behavioral assessments undermine all subsequent behavioral treatment planning. Examples include:

- L.Q.'s BSP suggests that, as a replacement behavior for his aggression, L.Q. should stand up, move around, and "feel[] around the walls" as an indication that he wishes to go for a walk. L.Q. is legally blind. The suggested replacement behavior to "feel[] around the walls" is demeaning and deviates grossly from generally accepted professional standards.

- L.Q.'s BSP also suggests that rectal digging may be an appropriate self-stimulatory behavior to engage in when he is in a private place. Encouraging as a replacement behavior an activity that can easily lead to injury or illness evidences questionable clinical judgment.

- BSPs for Y.B., K.C., and G.L. include the planned use of manual holds or restraints, a gross departure from generally accepted professional standards.

NWGRH fails also to collect sufficient behavioral data on which to base treatment decisions, and staff told us that no data at all are collected on replacement behaviors. Generally accepted professional standards require a mental health professional to analyze objective data concerning symptoms or behavior, and not merely anecdotal information. The lack of accurate behavioral data hinders accurate evaluation of the progress, or lack of progress, made by patients. Accordingly, actions by treatment teams are often based on inaccurate and limited data, leaving teams at risk of making decisions that are not clinically indicated. Examples include:

- D.I. has a behavior plan to reduce his intrusiveness, and his prior treatment plan included a communication goal to "verbally express wants, needs, and feelings with intelligibility." His new plan discontinues the communication goal without addressing whether he had made any progress. Improved communication skills could help reduce maladaptive, intrusive behaviors, and the team's decision to drop that goal does not appear to be based on objective data.

- O.N.'s BSP cites baseline data from a previous admission in 2005-06, and includes no data from his current admission, even though he had been at the Facility for at least four months in 2007.

- The replacement behaviors on F.C.'s BSP are identical in 2005 and 2007, although there are no data to determine whether he has made any progress in acquiring replacement behaviors. The data on his target behaviors, however varies widely, suggesting that whether or not he acquired replacement behaviors, they were not serving the purpose of reducing maladaptive target behaviors.

Behavioral data in individual charts is not current, and appears typically to be updated only annually. The failure to implement timely behavioral supports, to evaluate and revise behavior plans as clinically indicated, and to collect objective data with which to support clinical decisions are all egregious departures from generally accepted professional standards.

C. Seclusion and Restraints Are Used Inappropriately

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, the State may not subject patients of NWGRH to seclusion and restraint "except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training." Id. at 324. Generally accepted professional standards require that seclusion and restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. NWGRH's

use of seclusion and restraints, including medication used as a chemical restraint, substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

Given the deleterious effects of seclusion and restraint, and the fact that these measures restrict patients' rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like NWGRH reduce their use of seclusion/restraint by addressing behavior problems with less intrusive and restrictive strategies. We found that, while NWGRH has reduced the use of physical restraint and seclusion — which is commendable — the use of chemical restraint remains high, and when physical restraint and seclusion are used, the time periods that patients are subject to them is excessive.

Throughout the Facility, staff effort is focused primarily on controlling patients rather than treating them and replacing their maladaptive behaviors. On the adult mental health units, for example, only two of the 110 patients had behavior plans, despite many instances of challenging behaviors. Untrained staff lack the skills necessary to handle the large number of highly challenged patients who are dangerous to themselves or others or who have specialized needs. Not surprisingly, we found that in these difficult circumstances, staff resort to seclusion, restraint, and, secondarily, PRN medication, in lieu of appropriate treatment. Restrictive interventions clearly are used in place of active treatment, as punishment, and for the convenience of staff at NWGRH, contrary to generally accepted professional standards.

Use of antipsychotic medications for behavior control is chemical restraint. We found numerous instances where medications are being used as a form of behavior control, rather than as form of treatment for symptoms of psychosis. In many of these instances, the patient had no behavioral treatment plan, or the existing behavior plan was not utilized sufficiently. For example, N.Y. has been given multiple PRN medications for behavior control, including Ativan, Zyprexa, Thorazine, Geodon, and Haldol. N.Y. did not have a behavioral treatment plan in place when he was given any of these medications. The use of medications as chemical restraint, especially when there is no behavioral treatment plan in place, is a substantial departure from generally accepted professional standards. Moreover, the use of medications for these purposes has a significant potential for harm because of the side effects linked to exposure to antipsychotic medications, including irreversible motor

disorders, such as tardive dyskinesia, and the inability to control levels of glucose and lipids in the blood.

Furthermore, in a significant departure from generally accepted professional standards, NWGRH does not ensure that seclusion and restraints, including manual holds and PRNs, are used only as a last resort and not in the place of active treatment, as punishment, or as a convenience for staff. In some BSPs, such as those of Y.B., K.C., and G.L., restraints are written right into the program.

Our review also noted that, while the use of physical restraints and seclusion at NWGRH is relatively low compared to the other State Psychiatric Hospitals we visited, the duration of the restraint or seclusion is often extended. The following uses of mechanical restraint illustrate their extended use at NWGRH:

- On September 14, 2007, L.C. was mechanically restrained for four hours; the day before, L.C. was also mechanically restrained for four hours. On September 11, 2007, just two days previous, L.C. was mechanically restrained for eight hours, while the day before she was mechanically restrained for nearly three and a half hours;

- On September 13, 2007, N.G. was mechanically restrained for nearly three hours;

- K.R. was mechanically restrained for three and a half hours on August 25, 2007; he had previously been restrained for the same length of time on April 28, 2007;

- On May 13, 2007, E.G. was mechanically restrained for over two and a half hours; she had previously been restrained for three hours and 15 minutes on April 17, 2007;

- T.I. was mechanically restrained on April 28, 2007, for four hours;

- On April 15, 2007, B.M. was mechanically restrained for nearly seven and a half hours; and

- On April 4, 2007, O.D. was mechanically restrained for nearly ten hours.

As with mechanical restraints, use of seclusion at NWGRH, when used, is often extended:

- On September 10, 2007, L.C. was held in seclusion for four hours; as noted above, over the next four days L.C. also spent nearly 20 hours in mechanical restraints;

- On July 4, 2007, K.N. was held in seclusion for seven hours and 45 minutes; and

- On June 30, 2007, S.N. was held in seclusion for seven hours.

The extended use of mechanical restraints and seclusion at NWGRH suggests that they are not being terminated as soon as the person is no longer a danger to himself or others. The failure to terminate the use of mechanical restraints or seclusion when the person is no longer a danger is a substantial departure from generally accepted professional standards.

In addition, contrary to generally accepted practices, we found insufficient review of restrictive programs by the Facility's human rights committee, and inappropriate exclusion from treatment as a punishment for problem behaviors. Examples include:

- S.K. was restricted from day treatment for one week because he tried to kiss a staff member.

- U.W. was restricted from day programs because he brought cigarettes back to the unit.

- B.R.'s behavior contract includes "24 hour social isolation" and "24 hours media restriction" that do not appear to have been approved by the human rights committee.

D. Medical Care Is Inadequate

Although NWGRH patients are entitled to receive adequate health care, see Youngberg, 457 U.S. at 315, the Facility's basic medical care and nursing services substantially depart from generally accepted professional standards. NWGRH, like GRHA, fails to provide basic medical care and has inadequate clinical oversight, pharmacological practices, medication administration, infection control, physical and nutritional management, emergency preparedness, and staffing. Our findings regarding medical care echo many of those previously made in the State's own survey by the Medical College of Georgia.

1. Inadequate Clinical Oversight

The major role of clinical oversight in any institution is to ensure that generally accepted professional standards of practice and accountability are maintained. These standards require that nursing departments have a nursing and medical quality assurance program. Such a program provides internal monitoring for a nursing department and permits a facility to identify its problematic areas and correct them. A regular review of provided services also allows the nursing department to ensure that the services it purports to provide are those that it actually provides.

A quality assurance program for nursing consists of a number of monitoring instruments that measure the quality of care and services that are provided by the nursing department. These data are then regularly reviewed, analyzed, tracked, and trended. For areas that yield a low level of compliance, a plan of correction should be developed and implemented to increase the compliance rates for areas that are found to be deficient. Monitoring permits nursing management and facility administration to be aware and responsive to the needs of a department. It also assists nursing management in determining what types of interventions are needed when problem areas are identified and in tracking outcomes after interventions have been initiated.

NWGRH's nursing department does not have a program that monitors, tracks, identifies trends, and recognizes when a particular system is in need of corrective action. The data provided in response to our request for all nursing monitoring data, which was sparse, was not able to be interpreted in any meaningful way. Predictably, then, NWGRH's nursing services have several problematic areas that have not been identified by nursing leadership and, as a result, poor nursing practices have not been addressed.

Interviews with nursing management and staff confirmed that monitoring, if it is done at all, is done informally and inconsistently. Indeed, the lack of monitoring is disturbing given that the Medical College of Georgia survey identified problems with NWGRH's nursing care, but no actions have been taken to address these problems.

2. Failure to Provide Basic Medical Care

Effective medical services depend on timely, thorough assessments and monitoring. Generally accepted professional standards require nursing assessments to be designed to collect

specific, individual data to assist the team and the patient with case formulation, diagnosis, and treatment planning. The nursing assessments we reviewed at NWGRH did not meet these standards. At best, the nursing assessments were superficial and had little to no clinical relevance. Based on our review, NWGRH does not have a system in place ensuring that nursing assessments and documentation are adequate, complete, and accurate. For example, upon her admission, E.Y. was noted to be at risk for falls. The nurse's note indicates that, on the same day as her admission, E.Y. fell in her room and complained of leg pain. The following day she fell twice, and a nurse noted she had a knot on the back of her head. Her assessments following the falls, to the extent they were performed, do not indicate whether any vitals signs were taken, which leg was injured, or whether a neurological check was conducted. E.Y. had numerous other falls that lacked adequate nursing assessments — she fell a total of six times in one month without any proactive interventions except being placed in a bed with side rails. E.Y. experienced a dramatic change in her mental status following one fall: she became drowsy, her speech became slurred and disconnected, and she required hospitalization for a procedure to relieve pressure on her brain. In short, E.Y. was not appropriately assessed by nursing to determine her status after each fall. E.Y.'s treatment plan indicates that physical therapy could have been consulted for her risk of falls, but no such consult was initiated. The failure of basic nursing care and lack of interventions to address her risk of falls resulted in significant harm to E.Y.

The nursing assessments for O.G. were similarly incomplete. O.G. was sent to the emergency room for dehydration, malnourishment, and medical instability. But the nursing notes stated only that he was sent to the emergency room for evaluation — no symptoms or vital signs were recorded. The note upon his return to NWGRH included orders to encourage oral intake; no further assessment of his status was included in his record. D.J. was also transported to an emergency room without an adequate nursing assessment. In her case, the nurse's note indicated that D.J. had symptoms suggesting a possible stroke or infarction.[7] But there is no indication of when these symptoms began, and no vital signs were taken or neurological checks conducted before D.J.'s transportation to the emergency room. The nursing assessment, as with the cases described above, was incomplete and unacceptable.

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[7] Infarction is a condition in which tissue dies because its blood supply is blocked.

We also reviewed numerous assessments lacking information required for basic medical care. For example, the psychiatric nursing assessment for K.H. presented only a generic picture of his condition at admission. The only written description of him noted that he was "agitated" and that he was "cooperative at times" and "uncooperative at times." While the nurse indicated that he had Hepatitis C and tachycardia,[8] his problem list did not include either of these issues. The psychiatric nursing assessment for another patient, D.O., was incomplete. Although the nurse noted that the patient had stomach surgery resulting from a gunshot wound to the abdomen, the only related documentation was vague: "some bowel and kidney complications." D.O. was taken to the hospital for severe diarrhea and nausea several days after this incomplete assessment. Similarly, while the nursing assessment for M.N. indicated that she had hypertension, cellulitis, and a urinary tract infection, it failed to indicate that she was significantly obese. Such an omission places her at medical risk and is also a factor in selection of an appropriate psychotropic medicine. The omission extended to treatment: M.N.'s treatment plan did not address her obesity in any way. Thus, the nursing assessments at NWGRH are inadequate; they do not facilitate sound clinical judgments in planning appropriate interventions and place the patients residing there at significant risk for harm.

The health care plans at NWGRH are similarly inadequate. The purpose of a health care plan is to guide therapeutic interventions systematically, document progress, and achieve the expected individual outcomes. These plans should be individualized and should identify priorities for care and interventions that are consistent with current generally accepted professional standards. The numerous plans we reviewed all had essentially identical goals, objectives, and recommendations, reflecting a lack of individualization and no identification of priorities in a given patient's care. The listed interventions provided no guidance regarding treatment modalities, and the plans failed to include proactive interventions addressing risk factors.

We reviewed a sample of health care plans for NWGRH patients identified as at risk for aspiration. None of the health care plans included aspiration as a health risk. Proactive interventions, such as obtaining lung sounds and oxygen saturation to determine changes in health status, were absent in

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[8] Tachycardia is the medical term for a rapid heart rate, usually defined as over 100 beats per minute.

the health care plans for these at-risk patients. Instead, the health care plans we reviewed included the generic statement "monitor and maintain good physical health over the next 12 months." The harm caused by non-individualized treatment can be seen in the following examples:

- E.D. was sent to the hospital because of coffee ground emesis,[9] respiratory congestion, and possible pneumonia. E.D. is also at risk for aspiration. But his health care plan did not include these health issues or related interventions to assist staff in providing care.

- D.H. was diagnosed with the infectious disease methicillin-resistant staph ("MRSA") and is also at high risk for aspiration due to gastro-esophageal reflux disease. His health care plan did not include either of these major health issues nor did it include regular assessment of his health status. The generic quality of his health care plan provides no guidance to staff.

- T.H. has been identified as at high risk for aspiration. His health care plan did not include this risk and therefore does not provide for interventions to prevent aspiration or assess any potential status change. T.H. has been sent to the hospital three times in three months for episodes of difficulty breathing, rhonchi,[10] lethargy, and pneumonia. Despite repeated hospital visits, his health care plan requires no proactive assessments or interventions.

- N.N. has similarly been identified as at high risk for aspiration and has no health care plan that addresses this risk. She too has endured repeated trips to the hospital for episodes of dehydration, fever, lethargy, and possible aspiration pneumonia.

- K.D. has been sent to the hospital twice for aspiration pneumonia and choking; her health care plan did not include aspiration as a risk.

- D.M. was sent to the hospital four times in two weeks: the first time for fever, cough, and respiratory distress, the second time for respiratory distress and symptoms of

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[9] Coffee ground emesis is the medical term for vomit that contains blood.

[10] A coarse rattling sound usually caused by the accumulation of mucus or other material in a bronchial tube.

pneumonia, and the third and fourth times for pneumonia. Her health care plan did not include her risk for aspiration or any preventative interventions.

- R.H. was sent to the hospital for shortness of breath, cough, and pneumonia, but R.H.'s health care plan did not include her risk for aspiration or any preventative interventions.

Health care plans at NWGRH are alarmingly inadequate. They provide no clinical template for health care and fail to identify and address significant health issues so that positive outcomes may be achieved. Many patients suffered acute health issues; their health care plans failed to address these issues, and were not modified to prevent recurrences. The health care plans at NWGRH depart substantially from generally accepted professional standards, resulting in harm to patients.

3. Pharmacology Practices are Inadequate

Medication practices at NWGRH substantially depart from generally accepted professional standards in several critical respects. Contrary to accepted practice, pharmacological treatments are frequently the only interventions used to manage symptoms and behaviors, as discussed in Section III.C, supra. Many patients receive psychotropic medication – or multiple medications – for the purpose of sedation or to manage behavior, without underlying behavioral support plans. N.Y. and E.G., discussed previously, are two egregious examples of patients who received multiple medications for disruptive behavior without any behavioral support plans in place.

We also found medication prescription practices that are inconsistent with generally accepted professional standards. Polypharmacy, the practice of prescribing multiple medications to address the same indications, is widespread, and many records lack appropriate justification for this practice. For example, K.U., K.R., and K.N. were each receiving five such medications without sufficient clinical justification. Moreover, a number of medications were prescribed (and in some instances, not prescribed) in a manner inconsistent with generally accepted professional standards. For example, we observed orders for the emergency administration of Depakote and serotonin-specific re-uptake inhibitors, although these medications take weeks to be effective, and are thus inconsistent with emergency dosing. These practices substantially depart from generally accepted professional standards in pharmacology.

4. Inadequate Medication Administration

Generally accepted professional standards dictate that medications be administered according to nursing procedures that ensure that the correct patient receives the prescribed dosage of the prescribed medication by the prescribed route at the prescribed time. Moreover, generally accepted professional standards require that nursing staff properly complete Medication Administration Records ("MARs"). Among other things, MARs list current medications, dosages, and times that medications are to be administered. Proper and timely completion of the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. Failure to follow accepted MARs protocol may result in patients not receiving medications or receiving them too frequently, which could result in serious harm.

Our review of the MARs revealed numerous instances in which NWGRH administered medicine in manner that deviates substantially from generally accepted professional standards. Specifically, we found MARs that had blanks and MARS that were signed before medication was actually administered or signed in bulk after all medication had been administered. We also found missing signatures in the Narcotics Logs, where the on-coming and off-going nurses are to sign after the narcotics are counted together. Because narcotics have powerful and potentially addictive effects and are often classified as controlled substances, NWGRH's failure to account properly for their administration is deeply troubling. Also troubling is the failure of the nursing staff to understand their duty to report the errors indicated above as medication variances. These errors, and the failure of nurses to record them as variances, indicate both a gross underreporting of medication variations at NWGRH and a serious lack of supervision of medication administration.

5. Inadequate Infection Control

Generally accepted professional standards require adequate infection control. The components of an adequate infection control program fall into two general categories: surveillance and reporting; and control and prevention.

Surveillance and reporting include data collection on infections acquired in the community before admission to NWGRH and on infections acquired while residing at the Facility. These data can be used to establish baseline infection rates for different units to determine problem areas or areas where

in-service education could lower infection rates. This information can also be used to identify outbreaks of infections rapidly so that concentrated efforts can be initiated to prevent the spread of the infection.

In addition, Facility personnel should be monitored and data analyzed for possible exposure to, or as the source of, communicable and infectious diseases. The environment itself must be monitored as a source of potential infection hazards, especially during outbreaks of infection. Further, the Facility must report all communicable diseases to the appropriate health authorities in the State.

Control and prevention activities are of equal importance in an infection control program. In general, developing policies and procedures, staff training, patient educational programs regarding communicable diseases, and regular committee review of infection control activities are components of a infection control program that complies with generally accepted professional standards.

NWGRH's infection control program fails to meet these standards. NWGRH focuses on data collection at the expense of adequate treatment of patients with infectious diseases. The Infection Control Nurse has virtually no connection with the unit staff actually caring for patients with infectious diseases; the Infection Control Nurse does not review, and plays no role in developing, health care plans for these patients. Unsurprisingly, we found numerous patients with infectious diseases who had no provision in their respective health care plans for interventions related to their infectious diseases:

- One patient, E.E., was noted to have heavy growth of MRSA. Her medical record did not, however, reflect any treatment plan addressing either the care of the lesion or the need to take precautions related to it. The record did include a nurse's note that a call had been placed to the Infection Control Nurse to discuss MRSA compliance, but the documentation indicated that there was no answer. We found no other documentation indicating that the infection control program played any role in ensuring that E.E. received proper treatment or that other patients in her unit were protected.

- The admission notes for K.H. indicated that he had Hepatitis C, but his medical record included no treatment plan for this issue. As a result, K.H. was not provided with any type of education regarding transmission of the

disease or needed life-style changes that may have led to a long-term positive outcome. Further, we found no indication that the infection control program had any involvement with his case.

- Echoing the case of K.H., we found seven patients residing in the same unit and included in the infection control list as having Hepatitis B. None of their health care plans mention Hepatitis B, nor did we find any indication that the infection control program was involved in their cases.

NWGRH's infection control data collection efforts have no accompanying analysis regarding possible unit-level transmission of infectious disease. Moreover, NWGRH has not performed an analysis to demonstrate the efficacy, or lack thereof, of the activities and interventions of the infection control program. Our review found no data addressing employee health issues or patients who refuse tuberculin skin tests or immunizations. Further, there is no system in place ensuring that infection control data collected throughout the Facility is reliable, and data reliability from the units is problematic. The unreliability of infection data and the limited use to which it is put demonstrates that the infection control program at NWGRH is inadequate. Consequently, patients are at a high risk for harm.

6. Inadequate Physical and Nutritional Management

Generally accepted professional standards dictate that an effective physical and nutritional management system include: the identification of patients who are at risk for aspiration/choking and the assignment of an appropriate risk level; the identification of patients' triggers or symptoms of aspiration; adequate assessments of safe positioning for the 24-hour day; clinically-justified techniques, based on the assessment, that ensure safety during daily activities; the development and implementation of a plan containing specific instructions for the techniques determined by the assessment, with clinical justifications; the provision of competency-based training to all staff assisting these patients regarding individualized dysphagia plans; the development of a method to monitor, track, and document clinically objective data, including triggers, lung sounds, oxygen saturations, and vital signs, to determine if treatment interventions are effective or in need of modification; the development of a mechanism for reporting triggers that generate an immediate response from a physical nutritional management team ("PNMT") to re-evaluate the plan and its implementation; development of an overall monitoring system

conducted by members of the PNMT to ensure that plans are being consistently implemented and that this monitoring is most intense for those with the highest level of risk; and assurance that this system is effective so that it may be transferred into the community.

NWGRH patients residing at the DSU who are at risk for aspiration are not provided adequate assessments, interventions, proactive monitoring of symptoms, and regular treatment plan monitoring, which places them at significant risk for harm. NWGRH does not provide these patients with physical and nutritional management care consistent with generally accepted professional standards.

None of NWGRH's various disciplines, including nursing, physical therapy, occupational therapy, speech pathology, and dietary management, have the requisite specialized training or expertise in treating patients with physical and nutritional management needs. NWGRH fails to identify patients who have physical or nutritional management issues adequately, and the draft policies NWGRH has developed in this area fall far short of addressing the individualized needs of persons at risk for aspiration.

NWGRH's failures in training its staff and in identifying patients having physical and nutritional management issues includes patients facing serious risks of harm from aspiration and choking. In our review, we found no written criteria that adequately identified patients at risk for aspiration and choking. When asked, staff members were unable to articulate how to identify patients at risk for aspiration. Even for those patients who had been identified as at risk, NWGRH did not assess the degree of risk. Patients with recurrent episodes of aspiration pneumonia would, for example, normally be considered at the highest level of risk, but NWGRH made no such designation. As a result, NWGRH does not focus its most intensive, proactive treatments and interventions on the patients who need them. Indeed, there is little difference in the clinical care and treatment plans for patients who had no designated risk of aspiration and for patients who had a significant risk of aspiration.

For example, NWGRH designated four patients living on one unit as being at risk for aspiration. Our review of the alternative positioning for all of these patients showed that each patient had the same three generic alternative positions. None had clinical assessments indicating that these positions were evaluated as safe. Nor did we find follow-up assessments

indicating that these positions were safe. The alternative positions for these patients may therefore actually increase their risk for aspiration; we found no clinical data indicating otherwise. This lack of safety assessments extended to other high-risk activities, including oral care, bathing, dental appointments, and during sleep.

The mealtime plans we reviewed also lacked information to guide staff in feeding patients designated as at risk for aspiration. Mealtime plans for tube-fed patients — a group at the highest risk for aspiration — contained no special instructions for positioning during feeding or how long after the feeding the patient should remain in a specific upright position. Moreover, staff assigned to assist patients with meals and other activities did not receive competency-based training on carrying out the requirements of mealtime plans or treatment plans. The widespread absence of information guiding the treatment of at-risk patients is therefore compounded by the absence of any system to ensure that staff are competent in adequately executing treatment and mealtime instructions.

We observed numerous instances of inadequate staff assistance during mealtimes. Staff did not follow any procedure in keeping patients upright after meals. Our mealtime observations also showed that patients in wheelchairs were not in correct body alignment, thereby increasing their risk of aspiration. We observed a number of these patients coughing and gagging throughout their meals. Staff members stated that such coughing and gagging was a regular occurrence, and further indicated that they respond by feeding the patients slowly. This is not what we observed. Instead, we observed staff members responding to coughing and gagging by encouraging more food and fluids, a practice which increases the risk of aspiration. Furthermore, staff members did not respond to episodes of coughing or gagging by calling a nurse for assessment before continuing a meal. Nor did staff document these episodes of coughing and gagging — known triggers or symptoms of aspiration — in the patients' charts.

The failure to document episodes of coughing and gagging at mealtimes is symptomatic of NWGRH's deficiencies regarding aspiration risk. NWGRH does not identify individualized symptoms of aspiration or triggers to be monitored for patients who are at risk for aspiration. Consequently, no clinical data exists that would permit the PNMT team to evaluate the effectiveness of its interventions, except an actual episode of pneumonia, aspiration pneumonia, or respiratory distress. Without clinical data gathering that would enable early intervention to prevent an

episode of aspiration or aspiration pneumonia, NWGRH operates reactively, resulting in harm.

We observed such reactive treatment in the case of N.T., who displayed chronic symptoms of aspiration that were inadequately addressed. N.T. had been on a pureed diet with liquids thickened to a honey consistency for over a year. Interviews with staff indicated that N.T. had significant difficulties in swallowing, and would cough, hold food in his mouth, and refuse food during mealtimes. His record contained only a bare statement that his swallowing function had declined, but no monitoring appears to have been conducted. N.T. eventually developed unstable vital signs and was sent to the community hospital, where he was diagnosed with aspiration pneumonia. Upon his return to NWGRH, all of his previous treatment plans were reinstated without review. NWGRH ultimately determined that the diet it had provided to N.T. for at least a year had been causing him to aspirate. He now receives nothing by mouth and is given all nourishment through a tube.

The example of N.T. also shows that NWGRH does not initiate 24-hour dysphagia treatment plans even when an acute event, such as aspiration pneumonia, occurs. Such a plan should contain specific and individualized instructions and proactive interventions to address all activities during a patient's 24-hour day. But staff perception of N.T., as a result of their lack of training and expertise in dysphagia, is that he is no longer at risk of aspiration because he now has a tube. But N.T. does, in fact, remain at high risk for aspiration, a fact only partially reflected in the speech therapist's note that N.T. "could remain at risk for aspiration." N.T. continues to be at significant risk for harm.

N.T. is not the only patient at risk for harm due to the lack of safe, appropriate, and adequate interventions. Our review yielded a number of other examples:

- Y.O. has issues with weight loss and has had episodes of vomiting, difficulty in swallowing, coughing, and elevated temperatures. He has had several tests showing that he has a significant swallowing disorder and that he aspirates, but there has been no systematic tracking of his triggers for aspiration. He has not been given a treatment plan or intervention that adequately address his dysphagia and aspiration. Y.O. is therefore at risk for harm.

- N.N., a patient at risk for aspiration, was repeatedly sent to the emergency room for dehydration, fever, lethargy, and

pneumonia. Staff members indicated that she coughs frequently during mealtime. Nevertheless, NWGRH does not regularly collect data indicating when she began to experience triggers or how often they occurred, nor were lung sounds and oxygen saturation levels regularly taken to note changes in her status. Without this data, NWGRH is not adequately monitoring her aspiration risk.

- D.M. is also at risk for aspiration. She has had repeated visits to the emergency room for fever, cough, respiratory distress, bronchitis, and pneumonia. NWGRH has failed to institute proactive interventions and a systematic review of her condition, despite her repeated visits to the emergency room.

The lack of effective response by NWGRH, even to repeated acute instances of illness, is demonstrated in three other patients at risk for aspiration that we reviewed, each of whom made repeated trips to the emergency room. K.D. was sent to the emergency room three times — twice on the same day — for choking, turning blue, and pneumonia. E.N. was sent four times with multiple seizures, medication toxicity due to dehydration, lethargy, and aspiration pneumonia. And T.H. was sent to the emergency room three times for difficulty breathing, rhonchi, and pneumonia.

These examples demonstrate that there is no system in place at NWGRH to ensure that patients at risk for aspiration are provided with safe, appropriate, and adequate treatment interventions. Patients with dysphagia who have experienced recurrent respiratory distress, pneumonia, or aspiration pneumonia are not comprehensively reevaluated to assess the appropriateness of the current treatment plan and to modify interventions when necessary. The failure to reassess these patients and to provide proactive interventions is a gross departure from generally accepted professional standards. These deficiencies have resulted in harm and continue to place patients with physical and nutritional issues at serious risk of harm.

7. Emergency Preparedness Is Inadequate

In accordance with generally accepted professional standards, all staff should be well-trained in emergency preparedness, aware of emergency materials and where they are located, and conduct sufficient practice codes to be able to perform adequately when confronted with an actual emergency. Appropriate emergency medical response also includes physical plant readiness.

NWGRH practices and procedures regarding emergency preparedness substantially depart from generally accepted professional standards. This deviation is well-illustrated by the medical emergency drills we reviewed, a significant number of which were failed drills. In several of the drills, there was an absence of leadership, as the first-arriving nurse did not take charge of the code. One drill continued for 14 minutes without a physician arriving, and the nursing manager was unable to find the site of the drill. These drills also featured a variety of improper practices, including improper use of the Automated External Defibrillator ("AED"), incorrect positioning of the victim, and an inability to perform CPR correctly. Indeed, a review of documentation for current staff members showed that 197 employees had not been certified in CPR, while 146 held expired CPR certifications. NWGRH has no system in place to ensure that staff are properly trained and updated in CPR. Perhaps more egregiously, the nurse executive indicated that he was unaware that there were significant issues regarding drills. These repeated errors and lack of training place patients at the Facility at significant risk for harm.

These serious deficits in training exist throughout NWGRH's emergency preparedness programs. For example, we observed nurses who did not know how to turn on oxygen tanks, despite emergency preparedness documentation indicating that they were completing this task daily. In once instance, we observed a nurse struggle to turn a tank on, ask another nurse for assistance, and, after several failed joint attempts, successfully turn the tank on only to discover that it was empty. The monitoring sheet for the oxygen tank, however, indicated that it was full. We found numerous other instances where oxygen tanks had not been checked appropriately, according to NWGRH's own documentation. This pattern of unacceptable nursing practice was prevalent throughout the Facility.

Nor were nurses trained appropriately in testing suction machines or AED. Suction machine testing done by nurses was superficial, essentially demonstrating only that the suction machines could turn on rather than actually perform their intended function. Documentation indicated, however, that the suction machines were tested daily to ensure functionality. Nurses were unaware of when AED batteries should be changed to ensure functionality, and we did not find a single AED with documentation showing the installation date for its battery. Failures with respect to testing emergency equipment and documenting such testing extended to supervision by Nurse Managers. The managers did not observe staff checking emergency

equipment, nor did they review the emergency equipment logs for accuracy.

Poor preparedness and training in handling emergency code drills has significant ramifications for NWGRH's response to actual emergency codes. Moreover, errors in that response are not likely to be corrected by NWGRH's emergency code review process. Our review of actual codes showed the review process to be both incomplete and superficial. These reviews lacked important information related to the conduct of the code and, further, made no recommendations to improve conduct of future emergency codes. For example, in two separate codes, NWGRH's official review indicated that the AED showed that no shock was necessary. But records from the code itself indicated that the AED had not actually been applied; application of the AED is necessary for the AED to show that no shock was necessary. The absence of any critical review of these emergency codes permits the deficient practices outlined above to continue. As such, NWGRH departs from generally accepted standards of practice both in the substance of its emergency preparedness and in its procedures for reviewing that preparedness.

8. Inadequate Staffing and Nursing Services

The deficiencies in medical and nursing care identified above are exacerbated by chronic staffing shortages. Generally accepted professional standards require facilities like NWGRH to have staff sufficient to provide nursing services that, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization.

The current nurse executive at NWGRH admitted that recruitment and retention has been a major issue for the nursing department. He reported that NWGRH needed to fill 68 Registered Nurse vacancies and 46 Licensed Practical Nurse vacancies. Further, according to the nurse executive, the nursing department was struggling to maintain minimum staffing ratios. Nevertheless, the nurse executive was unable to produce any meaningful data about which shifts and units had fallen below minimum staff ratios or departmental turnover rates. Shortages have also resulted in many units having inadequate nurse management. Despite the nurse executive's evident awareness of the nursing shortage, we found no indication that a system had been established to review the effect of the shortage on clinical outcomes.

Moreover, the State's own 2007 survey by the Medical College of Georgia noted the nursing staff shortage and its potential effect on the services provided to patients at the NWGRH. NWGRH's corrective action plan promised that staffing problems would be addressed, but the nursing executive was unable to articulate the safeguards that had been implemented to ensure safe practices during the current staffing shortage. Our review showed that a number of shifts at NWGRH fall below minimum staffing levels each week. The nursing executive reported that NWGRH was in the process of working on revising the policy for minimum staffing ratios, but he was unable to describe the model, or to produce any data or criteria, used in determining what would constitute adequate staffing levels.

NWGRH's failure to provide adequate nursing staff, along with the deficits in care and treatment that necessarily result from the critical and ongoing shortages at NWGRH, is a substantial departure from generally accepted professional standards.

E. Services to Populations with Specialized Needs Are Inadequate

1. Services to Patients with Limited English Proficiency Are Insufficient

Pursuant to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., and its implementing regulations, NWGRH is required to take reasonable steps to ensure meaningful access to their programs and activities by persons with limited English proficiency ("LEP"). See 45 C.F.R. Part 80 (Department of Health and Human Services regulations). Georgia's Mental Health Gap Analysis in May 2005 identified glaring deficiencies in mental health services available to persons with hearing impairments or limited English proficiency. Although the State has adopted a Limited English Proficiency and Sensory Impaired Client Services Manual, we saw little evidence that the policies outlined in the Manual were followed. Examples include G.R., whose record indicates that he was unable to receive adequate treatment and services because of his limited English language ability. U.M. also has extremely limited English language ability, which made it impossible for him to assist in the investigation of his unexplained injury – a broken clavicle. The language barrier thus was a barrier to his participation in treatment and to efforts to protect him from future harm. The records of two acutely psychotic patients, J.P. and O.G., state that they "refused" interpretation services, but do not evidence any attempt by the Facility to address these refusals, which

effectively denied these patients psychiatric care. NWGRH's failure to ensure that meaningful access to necessary services is being provided to persons with LEP violates federal law.

2. Services to Patients with Sensory Impairment Are Insufficient

Title II of the Americans with Disabilities Act prohibits discrimination against persons with disabilities in the provision of benefits and services. Patients with vision and hearing impairments receive inadequate services at NWGRH. For example, at the time of our visit, there was no vision specialist on staff, no Braille instruction, and no orientation or mobility instruction for patients who are legally blind. To the contrary, staff told us that the treatment team had been reluctant to provide P.C. with a cane typically used by persons with limited sight for fear that he would use it as a weapon. The treatment plan for, another patient, P.P., who is legally blind, encourages him to "feel around the walls" as the preferred method of communicating that he would like to go for a walk. R.D., who has a hearing impairment, has been at the Facility for nearly two years. At the time of our visit, her treatment team was starting to pursue hearing aides for her; reportedly she had destroyed some in the past. Although the audiologist recommended using sign language, no staff member on her unit can sign. These examples evidence a profound lack of attention to the needs of patients with hearing and vision loss. They also suggest that the State has taken no effective action to remedy deficiencies in services to persons with sensory impairments, although these deficiencies were clearly identified in the State's own Mental Health Gap Analysis in 2005. These deficiencies violate federal law.

F. Inadequate Discharge Planning and Placement in the Most Integrated Setting

Federal law requires that NWGRH actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patients' needs. Olmstead, 527 U.S. at 607. Thus, at the time of admission and throughout a patient's stay, NWGRH should: (1) identify, through professional assessments, the factors that likely will foster viable discharge for the patient; and (2) use these factors to drive treatment planning and intervention. Without clear and purposeful identification of such factors, patients will be denied rehabilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The NWGRH discharge planning process substantially departs from generally accepted professional standards. Futhermore, NWGRH fails to meet the discharge planning principles stated in its own policies. The State's own audits of the "State of Georgia Behavioral Health System," prepared for the Governor in 2004 and 2005, identified egregious, systemic deficits in the coordination of care between NWGRH and the community. Based on our review of recent discharges from NWGRH, these same deficits persist. Specifically, we find that: (1) discharge plans are based on incomplete and inadequate assessments; (2) discharge planning services are not provided in accordance with NWGRH policies, although those policies are consistent with generally accepted professional standards; (3) inadequate coordination of care leads routinely to inappropriate discharges; and (4) discharge plans fail to address repeated readmissions.

1. Discharge Plans Are Based on Inadequate Assessments

Deficits in discharge planning begin with assessments upon admission. Complete and accurate assessments are essential to develop a treatment plan that can direct rehabilitation while in a facility and to form the basis for a viable discharge plan. In addition to the deficits in assessments discussed previously in this letter, the majority of charts we reviewed were missing assessments of social, vocational, functional, educational, self-care, and independent-living skills, particularly for those patients with short lengths of stay. The absence of information on critical aspects of functioning is a serious impediment to identifying the services and supports needed for these patients to transition successfully to community living. NWGRH fails to take advantage of available information regarding previous admissions, successful and unsuccessful treatments, and skills that needed to be developed to live successfully in the community. These failures greatly contribute to the high rate of recidivism at NWGRH.

As described previously, treatment teams at NWGRH routinely fail to adjust treatment plans even when objective signs show that the current plan is ineffective. Thus, patients do not receive supports and services to address problematic symptoms and behaviors that often disrupt community placements. The case of E.G., discussed previously, is one example. Her aggressive behaviors had disrupted 18 prior foster home placements, and the behaviors continued throughout her stay at NWGRH, requiring PRN medications 31 times, including just two days before her discharge. Despite this, there was no change in her treatment to address aggressive behavior.

2. Discharge Planning Services Are Not Provided in Accordance with NWGRH Policy

We found that, although NWGRH has a number of policies and procedures that articulate an adequate discharge planning and coordination of care process, in practice, these policies and procedures are not implemented. For example, NWGRH's policy for discharge of patients to personal care homes, which are among the most frequent placements, require adequate discharge planning to ensure that the home is suitable to the individual's needs. The procedures require the treatment team meeting to include a liaison from the Community Service Board ("CSB"), to develop a list of any specialized care recommendations, and facilitate a leave of absence pending discharge to the home in order to facilitate adjustment to the new home. We saw only one case in which the Facility's discharge policies had been followed, for A.N. In every other discharge that we reviewed there was noncompliance: no contact with the CSB, no specialized care recommendations, and no placement of patients on extended leave to the new home pending discharge. This noncompliance is particularly troubling because many patients discharged from NWGRH have major impairments in multiple areas of functioning, and would typically require substantially more supervision and oversight than a personal care home can usually provide.

NWGRH policy also notes that shorter lengths of stay may not permit contacts with outpatient providers before the day of discharge. In those cases, the case manager is supposed to contact the provider on the day of discharge and make aftercare arrangements, document these on the discharge letter, and fax it to the provider. We did not find a single aftercare plan complying with NWGRH policy in any of the discharge records we reviewed. For patients discharged to homeless shelters, the case manager is supposed to call and verify that the shelter is still receiving clients. We spoke with administrators of Must Ministries, a homeless shelter in Marietta, Georgia, who confirmed that, in their experience, NWGRH's practice does not follow this policy. Discharged patients typically arrive at the shelter without an advance phone call, and the shelter is not able to provide the level of care needed by individuals with serious mental illness or substance abuse disorders. These failures violate NWGRH policies and are a substantial departure from generally accepted professional standards.

3. Inadequate Coordination of Care Routinely Leads to Inappropriate Discharges

Contrary to generally accepted professional standards, NWGRH fails to provide adequate coordination and continuity of care, and this failure routinely leads to inappropriate discharges. The failure to appropriately coordinate continuing care results in numerous negative outcomes, including placements in inappropriate locations, re-admissions to the Facility, and unnecessary delays in community placement.

NWGRH declined to provide for our review aggregate information on the discharge location of all recently discharged patients. Nonetheless, during our review of individuals' records, we noted multiple examples of patients discharged to inappropriate locations, including patients with a history of repeat admissions discharged to homeless shelters without appropriate support:

- L.L. was discharged from her 18th admission to a Salvation Army homeless shelter, with no contact from the local Community Service Board.

- K.N. was discharged following his third admission with a bus ticket, five days of medication, and the address of a rescue mission shelter in a different state.

- K.T. was discharged from his third and fourth admissions to a homeless shelter.

Homeless shelters are not equipped to provide the level of care required for a patient being discharged from a psychiatric hospital, many of whom have severe and persistent mental illness.[11] NWGRH's own documents note that NWGRH's professionals are aware that shelters do not have sufficient structure or supervision for persons with mental illness. Patients discharged to homeless shelters are likely to return to the hospital and repeat the cycle of inadequate discharge multiple times. Research indicates that the best chance for a successful recovery outcome is achieved when the person receives adequate care during the first episode of the psychiatric illness and that the opportunities for successful recovery diminish on each future episode. NWGRH's failure to provide adequate coordination and

[11] Indeed, as we noted in the findings letter regarding GRHA, the Supreme Court, in Olmstead, stated that homeless shelters were inappropriate discharge locations. Olmstead v. L.C., 527 U.S. 581, 605 (1999).

continuity of care, routinely resulting in inappropriate discharges, is a substantial departure from generally accepted professional standards.

4. Discharge Plans Fail to Address Repeated Readmissions

In addition to many discharges to inappropriate locations without sufficient supports, we noted approximately 240 patients who were discharged and re-admitted to the hospital within the first nine months of 2007. Dozens of these patients had lifetime histories of more than 20 re-admissions. That so many patients go through the cycle of admission and discharge multiple times indicates significant flaws in the discharge planning process.

NWGRH is not adequately addressing the significant barriers to successful discharge that many patients face. NWGRH social workers identified housing as a primary barrier to community placement. The Chief of Social Work denied that sufficient substance abuse treatment was a placement barrier for those patients with substance abuse history, but in our review of discharge plans, we saw no referrals for this essential service. The State's own findings in the 2005 Georgia Mental Health Gap Analysis also discussed the dearth of sufficient Assertive Community Treatment teams, which serve as a vital link between the hospital and the community for participants. Assertive Community Treatment programs offer an array of services customized to individual needs, delivered by a community-based team of mental health practitioners, and available 24 hours per day. Our review of discharges from NWGRH suggests that this glaring gap in provision of services, and in particular for patients with a history of repeated admissions, is as great today as it was three years ago.

In most cases, neither formal or informal supports have been developed and prepared for use by patients transitioning from NWGRH. There is little indication that the Facility has attempted to locate, develop, or advocate for needed supports or services that NWGRH professionals acknowledge are needed to ensure successful transitions to community living. NWGRH's failure to address repeat admissions and barriers to successful placement deviates substantially from generally accepted professional standards.

IV. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at

NWGRH, the State of Georgia should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

The Georgia Psychiatric Hospitals shall provide their patients with a safe and humane environment and protect them from harm. At a minimum, the Georgia Psychiatric Hospitals shall:

1. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards. The Georgia Psychiatric Hospitals shall:

    a. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including those involving any physical injury; patient aggression; abuse and neglect; contraband; and suicide ideation or attempts;

    b. Require all staff to complete competency-based training in the revised reporting requirements;

    c. Create or revise, as appropriate, and implement thresholds for indicators of events, including, without limitation, patient injury, patient-on-patient assaults, self-injurious behavior, falls, and suicide ideation or attempts, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level; whenever such thresholds are reached, this will be documented in the patient medical record, with explanations given for changing/not changing the patient's current treatment regimen;

    d. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including, without limitation, abuse, neglect, suicide ideation or attempts, unexplained injuries, and all injuries requiring medical attention more significant than first aid. The policies and procedures shall require that investigation of such incidents that are comprehensive, include

consideration of staff's adherence to programmatic requirements, and are performed by independent investigators;

e. Require all staff members charged with investigative responsibilities to complete competency-based training on investigation methodologies and documentation requirements necessary in mental health service settings;

f. Monitor the performance of staff charged with investigative responsibilities and provide administrative and technical support and training as needed to ensure the thorough, competent, and timely completion of investigations of serious incidents;

g. Ensure that corrective action plans are developed and implemented in a timely manner;

h. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from patient aggression and abuse and neglect allegations, to ensure that such incidents are properly investigated and appropriate corrective actions are identified and implemented in response to problematic trends; and

i. Create or revise, as appropriate, and implement policies and procedures regarding the creation, preservation, and organization of all records relating to the care and/or treatment of patients, including measures to address improper removal, destruction, and/or falsification of any record.

2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards. At a minimum, such a system shall:

a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by the Georgia Psychiatric Hospitals, as well as the outcomes being achieved by patients;

b. Analyze the information collected in order to identify strengths and weaknesses within the current system; and

c. Identify and monitor the implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

B. Mental Health Care

1. Assessments and Diagnoses

The Georgia Psychiatric Hospitals shall ensure that their patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, the Georgia Psychiatric Hospitals shall:

a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments; and ensure that assessments include a plan of care that outlines specific strategies, with rationales, including adjustment of medication regimens and initiation of specific treatment interventions.

b. Ensure that psychiatric reassessments are completed within time-frames that reflect the patient's needs, including prompt reevaluations of all patients requiring restrictive interventions.

c. Develop diagnostic practices, consistent with generally accepted professional standards, for reliably reaching the most accurate psychiatric diagnoses.

d. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including, without limitation, maladaptive behaviors and substance abuse problems.

e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's

history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.

f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.

g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justified current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.

h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial assessments, progress notes, and transfer and discharge summaries, and require each clinical discipline's peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective action.

2. Treatment Planning

The Georgia Psychiatric Hospitals shall develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, the Georgia Psychiatric Hospitals shall:

a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards.

b. Ensure that treatment plans derive from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. At a minimum, this should include:

(1) Review by psychiatrists of all proposed behavioral plans to determine that they are compatible with the psychiatric formulations of the case;

(2) Regular exchange of objective data between the psychiatrist and the psychologist and use of this data to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies;

(3) Integration of psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap; and

(4) Documentation in the patient's record of the rationale for treatment.

c. Ensure that treatment plans address repeated admissions and adjust the plans accordingly to examine and address the factors that led to re-admission.

d. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.

e. Ensure that treatment plans are consistently assessed for their efficacy and reviewed and revised when appropriate.

f. Provide adequate and appropriate mental health services, including adequate psychological services, behavioral management, and active treatment, in accordance with generally accepted professional standards.

g. Provide psychologists with sufficient education and training to ensure:

(1) competence in performing behavioral assessments, including the functional analysis of behavior and appropriate identification of target and replacement behaviors;

(2) the development and implementation of clear thresholds for behaviors or events that trigger referral for a behavioral assessment;

(3) timely review of behavioral assessments by treatment teams, including consideration or revision of behavioral interventions, and documentation of the team's review in the patient's record;

(4) the development and implementation of protocols for collecting objective data on target and replacement behaviors; and

(5) assessments of each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.

h. Re-assess all patients at the Facility to identify those who would benefit from speech and communication therapy and provide sufficient qualified and trained staff to provide services to all patients who would benefit from this service.

i. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs, goals, and interventions, as well as discharge criteria.

j. Ensure that the medical director timely reviews high-risk situations, such as patients requiring repeated use of seclusion and restraints.

k. Develop and implement policies to ensure that patients with special needs, including co-occurring diagnoses of substance abuse and/or developmental disability, and physical, cognitive and/or sensory impairments are evaluated, treated, and monitored in accordance with generally accepted professional standards.

l. Develop and implement policies for patients exhibiting suicidal ideation, including for patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.

m. Develop a system to ensure that staff receive competency-based training on individualized plans, including behavioral support plans and interventions, and document this training.

n. Ensure that restrictive interventions receive appropriate review by a Human Rights Committee, or its equivalent, to guarantee any restriction of rights are necessary, appropriate, and of limited duration.

o. Ensure that all psychotropic medications are:

    (1) administered as prescribed;

    (2) tailored to each patient's individual symptoms;

    (3) monitored for efficacy and potential side-effects against clearly-identified target variables and time frames;

    (4) modified based on clinical rationales; and

    (5) properly documented.

p. Institute systematic monitoring mechanisms regarding medication use throughout the Facility. In this regard, the Georgia Psychiatric Hospitals shall:

    (1) Develop, implement, and continually update a complete set of medication guidelines in accordance with generally accepted professional standards that address the indications, contraindications, screening procedures, dose requirements, and expected individual outcomes for all psychiatric medications in the formulary; and

(2) Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, a documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely, critical review of the patient's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

C. Seclusion and Restraints

The Georgia Psychiatric Hospitals shall ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances i.e., when a patient poses an imminent risk of injury to himself or a third party — any device or procedure that restricts, limits, or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More particularly, the Georgia Psychiatric Hospitals shall:

1. Eliminate the use of planned (i.e., PRN) seclusion and planned restraint.

2. Ensure that restraints and seclusion:

   a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;

   b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;

   c. Are not used as part of a behavioral intervention;

   d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and

   e. Are used in a reliably documented manner.

3. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:

   a. The range of restrictive alternatives available to staff and a clear definition of each; and

   b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.

4. Ensure that if seclusion and/or restraint are initiated, the patient is regularly monitored in accordance with generally accepted professional standards and assessed within an appropriate period of time, and that an appropriately trained staff member makes and documents a determination of the need for continued seclusion and/or restraint.

5. Ensure that a physician's order for seclusion and/or restraint includes:

   a. The specific behaviors requiring the procedure;

   b. The maximum duration of the order; and

   c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.

6. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.

7. Ensure that at least every thirty minutes, patients in seclusion and/or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.

8. Ensure that immediately following a patient being placed in seclusion and/or restraint, the patient's treatment team reviews the incident within one business day, and the attending physician documents the review and the reasons for or against change in the patient's

current pharmacological, behavioral, or psychosocial treatment.

9. Comply with the requirements of 42 C.F.R. § 483.360(f) regarding assessments by a physician or licensed medical professional of any resident placed in seclusion and/or restraints.

10. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

D. Medical and Nursing Care

The Georgia Psychiatric Hospitals shall provide medical and nursing services to its patients consistent with generally accepted professional standards. Such services should result in patients of the Georgia Psychiatric Hospitals receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, the Georgia Psychiatric Hospitals shall:

1. Ensure adequate clinical oversight to ensure that generally accepted professional standards are maintained.

2. Ensure that patients are provided adequate medical care in accordance with generally accepted professional standards.

3. Ensure sufficient nursing staff to provide nursing care and services in accordance with generally accepted professional standards.

4. Ensure that, before nursing staff work directly with patients, they have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.

5. Ensure that nursing staff accurately and routinely monitor, document, and report patients' symptoms and target variables in a manner that enables treatment

teams to assess the patient's status and to modify, as appropriate, the treatment plan.

6. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.

7. Ensure that nursing staff are appropriately supervised to ensure that they administer, monitor, and record the administration of medications and any errors according to generally accepted professional standards.

8. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Record.

9. Ensure that all failures to properly sign the Medication Administration Record and/or the Narcotics Log are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.

10. Ensure that each patient's treatment plan identifies:

    a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;

    b. The related symptoms and target variables to be monitored by nursing and other unit staff; and

    c. The frequency by which staff need to monitor such symptoms.

11. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, the Georgia Psychiatric Hospitals shall:

    a. Actively collect data with regard to infections and communicable diseases;

    b. Analyze these data for trends;

    c. Initiate inquiries regarding problematic trends;

d. Identify necessary corrective action;

e. Monitor to ensure that appropriate remedies are achieved;

f. Integrate this information into the quality assurance review of the Georgia Psychiatric Hospitals; and

g. Ensure that nursing staff implement the infection control program.

12. Establish an effective physical and nutritional management program for patients who are at risk for aspiration or dysphagia, including but not limited to the development and implementation of assessments, risk assessments, and interventions for mealtimes and other activities involving swallowing.

13. Ensure that staff with responsibilities for patients at risk for aspiration and dysphagia have successfully completed competency-based training commensurate with their responsibilities.

14. Provide adequate, appropriate, and timely rehabilitation therapy services and appropriate adaptive equipment to each individual in need of such services or equipment, consistent with generally accepted professional standards.

15. Establish an effective medical emergency preparedness program, including appropriate staff training; ensure staff familiarity with emergency supplies, their operation, maintenance and location; conduct sufficient practice drills to ensure adequate performance when confronted with an actual emergency.

E. Services to Populations with Specialized Needs

1. Provide adequate services to patients with limited English proficiency or sensory deficiencies, consistent with the requirements of the State's Limited English Proficiency and Sensory Impaired Client Services Manual and federal law.

F. Discharge Planning

The State shall ensure that patients receive services in the most integrated, appropriate setting that is consistent with their needs and legal status and actively pursue the appropriate discharge of patients. More particularly, the Georgia Psychiatric Hospitals shall:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:

    a. The individual patient's symptoms of mental illness, psychiatric distress, or cognitive impairment;

    b. Any other barriers preventing that specific patient from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and

    c. The patient's strengths, preferences, and personal goals.

2. Ensure that the patient is an active participant in the placement process.

3. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.

4. Provide the patient adequate assistance in transitioning to the new setting.

5. Ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

6. Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services, including:

    a. Develop a system of follow-up with community placements to determine if discharged patients are

receiving the care that was prescribed for them at discharge; and

b. Hire sufficient staff to implement these minimum remedial measures with respect to discharge planning.

7. The State shall ensure that it provides community-based treatment for persons with disabilities consistent with federal law.

. . . . . .

V. CONCLUSION

We appreciate the cooperation we received from the Georgia Department of Mental Health Developmental Disabilities and Addictive Diseases, and the State's Attorney General's Office during our visit to NWGRH. We also wish to thank the administration and staff at NWGRH for their professional conduct, their generally timely responses to our information requests, and the extensive assistance they provided during our tour. Further, we wish to especially thank the hospital's staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at these facilities. Those efforts were noted and appreciated by the Department of Justice and our expert consultants.

Please note that this findings letter is a public document. It will be posted on the website of the Civil Rights Division. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on our website until 10 calendar days from the date of this letter.

As discussed in our letters of June 27, 2008, and November 20, 2008, we will forward our expert consultants' reports under separate cover once we are confident that you intend to use the reports to address the deficiencies outlined in our findings letters. These reports are not public documents. Although our expert consultants' reports are their work — and do not necessarily represent the official conclusions of the Department of Justice — their observations, analyses, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that State chooses to cooperate with us so we may provide them to you in the near future, and that you will give

this information careful consideration and use it to assist in your efforts at promptly remediating areas that require attention.

We are obliged by statute to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General is empowered to initiate a lawsuit, pursuant to CRIPA, to correct deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We remain amenable to expeditiously resolving this matter by working cooperatively with you. The lawyers assigned to this matter will be contacting your attorneys to discuss next steps in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General
Civil Rights Division

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Office of the Attorney General Of Georgia

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