**U.S. Department of Justice**

Civil Rights Division

*Special Litigation Section - PHB*
*950 Pennsylvania Avenue, NW*
*Washington, DC 20530*

May 23, 2006

The Honorable Anthony A. Williams
Mayor
District of Columbia
1350 Pennsylvania Avenue, N.W.
Washington, DC 20005

Re: CRIPA Investigation of St. Elizabeths Hospital, Washington, D.C.

Dear Mayor Williams:

I am writing to report the findings of the Civil Rights Division's investigation of the conditions and practices at St. Elizabeths Hospital ("St. Es"), in Washington, D.C. On March 16, 2005, we notified you of our intent to conduct an investigation of St. Es pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the DOJ authority to seek remedies for any pattern or practice of conduct that violates the constitutional or federal statutory rights of persons with mental illness who are served in public institutions.

As part of our investigation, in June 2005, we conducted an on-site review of care and treatment at St. Es with expert consultants in the areas of psychiatry, psychiatric nursing, psychology, environmental health and safety, and protection from harm. Before, during, and after our site visit, we reviewed a wide variety of documents, including policies and procedures, and medical and other records relating to the care and treatment of dozens of St. Es patients. During our visit, we also interviewed administrators, staff, and patients, and examined the physical living conditions at the facility. At the end of our tour, consistent with our pledge of transparency and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to counsel and facility and District officials.

We wish to express our appreciation to the staff of St. Es and to District officials for their assistance and cooperation during our investigation. We hope to continue to work with St. Es and the District of Columbia in the same cooperative manner in addressing the problems that we found. Further, we wish to particularly thank those individual St. Es staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment and improve the lives of patients at the hospital. Those efforts were noted and appreciated by us and our expert consultants.

Consistent with our statutory obligations under CRIPA, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal 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 St. Es violate the constitutional and federal statutory rights of its residents. In particular, we find that St. Es fails to provide its patients adequate: 1) protection from harm; 2) psychiatric and psychological care and treatment; 3) medical and nursing care and treatment; and 4) discharge planning and placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

## I. BACKGROUND

St. Elizabeths was initially established in 1855 as the Government Hospital for the Insane. In 1916, Congress officially changed the hospital's name to St. Elizabeths. By the 1940s, the hospital complex covered 300 acres, and housed 7,000 patients. In 1987, the federal government transferred the hospital to the District of Columbia, but retained ownership of the western campus.[1] St. Es is currently operated on approximately 197 acres of land located in southeast Washington D.C., specializing in inpatient care for people with acute, long-term mental health needs and forensic needs. St. Es patients and staff occupy approximately 15 buildings. Forensic patients are housed in the

[1] The federal government transferred St. Elizabeths to the District of Columbia, pursuant to Public Law 98-621. St. Es does not house any patients nor provide any services on the western campus.

John Howard Pavilion ("JHP"). Although St. Es is a 529-bed hospital, its census has declined over the years, and during our visit in June 2005, the census was 221 for forensic patients and 229 for civil patients, for a total of 450 patients.

## II. FINDINGS

### A. PROTECTION FROM HARM

Patients at St. Es have a right to live in reasonable safety and to receive adequate health care, along with treatment to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Brogsdale v. Barry, 926 F.2d 1184, 1190 (D.C. Cir. 1991) (citing Youngberg for proposition that pretrial detainees have a constitutional entitlement to a reasonably safe environment); Evans v. Washington, 459 F. Supp. 483, 488-90 (D.D.C. 1978) (constitutional rights to care and treatment and to be free from harm required institution to develop and implement certain programs and refrain from certain actions including prohibiting physical or psychological abuse, neglecting or mistreating residents, and requiring incidents of alleged abuse to be reported promptly and investigated). In order to protect patients from harm, the District has a duty to adequately supervise St. Es patients known to be suicidal. See, e.g., United States v. Hinckley, 672 F.2d 115, 132 n.112 (D.C. Cir. 1982) (noting obligation of jailer to control environment to protect suicidal prisoner from harming himself); Dinnerstein v. United States, 486 F.2d 34 (2d Cir. 1973) (veterans hospital held liable for not adequately supervising patient with history of known suicidal tendencies).

In our judgment, St. Es fails to provide its patients with a reasonably safe living environment. The facility too often subjects its patients to harm or risk of harm. St. Es patients are subjected to assaults and harm from elopements[2] and suicides. St. Es patients are subjected to undue seclusion and restraints. Resolution of these concerns is hampered by an inadequate risk management and quality assurance system, and inadequate investigations of abuse and neglect. Finally, St. Es patients suffer harm from an inadequate physical plant.

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[2] Elopements are incidents where patients leave St. Es' campus without authorization.

### 1. Assaults, Elopements, and Suicide Risks

Based on the four month period between January and April 2005, St. Es' documents reveal that there were at least 138 patient-to-patient altercations and 34 patient-to-staff altercations. During a number of the patient-to-patient assaults, there appears to have been little or no supervision. In several incidents, patients were subjected to life-threatening harm. This is particularly troubling given the history of assaults at St. Es, some of which have resulted in deaths, in the recent past. For example, on April 21, 2004, a 60-year-old patient beat a 76-year-old patient to death. The medical examiner's office ruled the death a homicide and identified blunt-impact trauma to the head and neck as a contributing factor. Similarly, on April 4, 2004, a patient-on-patient altercation resulted in the victim sustaining a cracked skull and broken neck and legs, and he was transported to a hospital in a comatose state. This victim remained in a coma for over a year and died on March 12, 2005. The alleged attacker has been charged with homicide.

More recently, on February 7, 2005, A.F.,[3] who was noted by staff to be acting "quite psychotic," was involved in an altercation with another patient, D.I., in the bedroom area of the unit. D.I. apparently kicked A.F. in the head until he was unconscious. A.F. was taken to the emergency room. In another example, on January 30, 2005, K.L. was assaulted by another patient in the day room, where she was grabbed by the hair and thrown to the ground. She was taken to the emergency room and received stitches for a laceration to her forehead.

In addition, we identified a pattern of patient-on-patient assaults on the wards' smoking porches, where no staff were present. For example, on January 30, 2005, Y.I. assaulted T.P. on the smoking porch, kicking her in the head and throwing a chair at her. Staff responded after hearing T.P. screaming. There were at least seven additional patient-on-patient assaults throughout this four month period on the smoking porches where patients are apparently allowed without supervision.

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

Over this same four-month period, there were 86 elopements. A substantial number of the elopements occurred when patients were supposed to be in the dining room or going to and from treatment. For example, H.G. eloped eight times over the course of three months, and five of those elopements were from the dining room. Additionally, six other patients eloped from the dining room over this four-month period. Despite these patterns, no corrective procedures have been implemented to address this high rate of elopements or to prevent elopements from the same common areas.

Patients at St. Es routinely leave the grounds of the hospital without authorization. Many of these patients simply walked off the hospital grounds, scaled the exterior fence, or did not return from community-based programs. In fact, we were told that the private security staff at St. Es are prohibited from requiring identification of, or detaining, patients who elope or attempt to flee the hospital.

These security deficiencies fail to protect St. Es patients from harm. For example, on January 15, 2005, F.I. was given one hour grounds privileges[4] at 4:00 p.m. He returned over four hours later at 8:15 p.m. with a crack cocaine pipe. On January 7, 2005, L.M. was accidentally let out for ground privileges and he has never returned.

In another example, on April 28, 2005, a staff member at the forensic unit reported finding a large yellow rope thrown over the exterior wall, apparently from the exterior side of the wall. Sheets were also found tied together in a trash can. However, there did not appear to be any further investigation or follow-up regarding this matter. By failing to implement accountability and control measures for the significant rate of elopements of patients with mental illness, the hospital is placing its patients, as well as the surrounding community, at risk of harm.

Finally, patients at risk for suicide receive inadequate care and supervision. St. Es does not have a clear policy for suicide assessment, evaluation, and follow-up. There are cases when patients' risks for suicides are not even assessed. In fact, in several nursing assessments, patients with suicidal ideations or tendencies were merely identified as having unsafe behavior towards self/others or self-care deficits towards

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[4] Patients with grounds privileges are allowed to leave their units and given access to St. Es' grounds, typically for an hour, but are not authorized to leave the St. Es campus.

self/others. This systemic failure to directly and adequately address suicidal risks eliminates prompt and effective interventions to monitor patients and prevent suicides and suicide attempts. For example, T.N.'s initial assessment did not include an assessment of suicidality because he was "disorganized." There are no documented attempts to follow up with this patient at a later date to complete his psychiatric assessment for dangerousness to himself.

When patients are assessed, patients who exhibit suicidal tendencies are not properly monitored and treated. For example, on February 22, 2005, P.O. was found by another patient in the bathroom where she was sitting on the toilet with a plastic bag around her head and a string around her neck. In response to her suicide attempt, the patient was inappropriately placed in four-point restraints to the bed and one-to-one observation for 24 hours. The standard of care is to place such a patient on special observation until a proper assessment and evaluation of the lethality of her suicidal ideation can be conducted. Four days later, P.O. re-attempted suicide, when, again, she was found in the bathroom, this time attempting to cut her wrists with a piece of glass. She was instructed to leave the bathroom and counseled, again an egregious departure from the standard of care. Moreover, there was no indication that St. Es attempted to determine where she obtained the plastic bag, string, or piece of glass.

In addition to the bathrooms serving as a common location for patients to attempt suicide, they contain serious suicide risks. For example, many of the bathrooms have hand-held showers, protruding knobs and open grab bars, which are serious suicide hazards.

**2. Seclusion, Restraints, and Pro Re Nata or "As Needed Medications"**

The right to be free from undue bodily restraint is the core of the liberty protected by the Due Process Clause from arbitrary governmental action. Youngberg, 457 U.S. at 316. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training."); United States v. Weston, 255 F.3d 873, 876 (D.C. Cir. 2001) (recognizing balance between

significant liberty interest to be free from unwanted chemical restraints and judgment of medical professionals); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990) ("It is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp. 2d 591, 619-20 (D. Md. 2001) (the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions); 42 C.F.R. § 482.13(f)(3) ("The use of a restraint or seclusion must be . . . [s]elected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; [and] . . . [i]n accordance with the order of a physician . . . ."); 42 C.F.R. § 482.13(f)(1) ("The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.").

Generally accepted professional standards dictate that seclusion and restraints: a) will be used only when persons pose an immediate safety threat to themselves or others and, absent exigent circumstances, after a hierarchy of less restrictive measures has been considered and/or exhausted; b) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; c) will not be used as a behavioral intervention; and d) will be terminated as soon as the person is no longer a danger to himself or others. In addition, generally accepted professional standards instruct that pro re nata ("PRN" or "as needed") psychotropic medications should be used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment, or used as punishment.

Although the reported incidents of St. Es' use of seclusion and restraints appear to have decreased in recent years, St. Es' uses of seclusion, restraints, and PRN medications substantially depart from generally accepted professional standards.

Of great concern is the pattern of seclusion and restraint usage in the forensic unit. From January through May 2005, patients on the forensic units were restrained or secluded for 1,387 hours on the weekends (Friday - Sunday) compared to 63.62 hours during the week (Monday - Thursday). This significant difference between the number of seclusion and restraint hours during the weekends and the weekdays is clinically inexplicable and most likely indicates an over-reliance on the usage of seclusion and restraints to compensate for shortage of staff and personnel on weekends.

Seclusion and restraint reporting appears to be inconsistent and/or inaccurate. For example, we identified a patient who wore a protective helmet and had been continuously placed on one-to-one supervision during the six months prior to our visit. Unit staff stated that his bed was wheeled into the day room at night for observation but denied that any seclusion or restraints were used. However, his bed was fitted with wrist restraints and a urinal. Unit staff claimed that the wrist restraints had not been removed because the key was lost. In our experience, the existence of the wrist restraints in combination with a urinal strongly suggests that this patient was restrained to the bed at night, notwithstanding the absence of any reporting or documentation.

According to generally accepted professional standards, bed side rails are physical restraints. Patients, particularly those who have problems with memory, sleeping, incontinence, or who get out of bed and walk unsafely without assistance, can become entangled in side rails when attempting to exit beds, and can be severely injured or killed as a result. Where side rails are used, they must be part of a patient's treatment plan that reflects that they are the least restrictive intervention then available and that alternative interventions are being explored to obviate their need. St. Es routinely uses bed side rails as a substitute for care and at the risk of patients' safety. For example, U.N.'s treatment plan states that he has a "High Risk for Falls," and the recommended intervention was to order side rails for his bed to address his restlessness and agitation in bed. Using side rails places this patient at greater risk of injuring himself because the rails will likely cause more agitation and cause him to attempt to climb over the side rails, thereby posing greater risks of strangulation, falls, bodily injury or death. In another example, R.E. attempted to get out of bed when both side rails were up. He fell and was found kneeling on the floor, bleeding from his forehead.

The seclusion rooms themselves are unsafe. Several seclusion rooms contained metal beds with exposed and pointed corners and screws. Furthermore, several seclusion rooms did not have necessary mirrors for staff to observe the patient at all corners of the room. These rooms present clear dangers to patients and are not acceptable. Patients in seclusion should be under constant observation in order to prevent them from injuring themselves. Seclusion rooms should be designed with mirrors in the corners below the ceilings to allow complete visibility and there should be no exposed corners, edges, or screws on which patients can accidentally or purposefully harm themselves.

When seclusion, restraints and/or PRN medications are frequently used with a patient, generally accepted professional standards require the treatment team to reassess interventions and, as necessary, modify the patient's treatment plan. Frequent use of seclusion, restraints and/or PRN medications is an indicator that a patient's diagnosis is erroneous and/or that the treatment plan is inappropriate, and may also indicate that staff are using them to replace active treatment, as punishment, or for the convenience of staff.

St. Es patients are routinely subjected to repeated uses of seclusion, restraints and/or PRN medication. Treatment plans are not adequately reviewed or revised to address these problematic patient outcomes. For example, I.M. was admitted to St. Es' forensic unit on April 11, 2005. In addition to routine medications, she received 57 PRN medications between April 12 and July 22, 2005. During this period, there was no evaluation of this patient's medication regimen or modification of her treatment plan. In another example, Y.I. received repeated PRN medications as well as other restrictions between April and May 2005 for repeated episodes of acting out and verbal threats, including punching a psychiatrist. Nonetheless, he was given ground privileges during this same period and he eloped. At some point after his return, he was transferred at least once to another unit where his behavior remained unmanageable. His treatment plan was never reviewed or modified to address his repeated episodes. Similarly, A.O. is a patient diagnosed with psychotic disorder. She has had repeated episodes of psychotic symptoms, agitation and assaultiveness toward her peers. Over the course of four and a half months, A.O. assaulted or attempted to assault other patients on three different occasions. Although PRN medication was ordered immediately after two of the assaults, her treatment plan was never reviewed and her regular medication management was never addressed.

Documentation surrounding the use of seclusion, restraints, and/or PRN medication, including the circumstances leading up to their use, fail to show that staff first attempted less restrictive interventions, that patients were an immediate danger to themselves or others, or the need for their continuation. In contravention of generally accepted professional standards, St. Es fails to release patients from seclusion and restraint when they are no longer a danger to themselves or others.

Patients receiving PRNs are routinely ordered PRNs for "agitation," which, contrary to generally accepted practices, fails to specify the exact nature of behaviors that require the administration of medication PRN. In addition, the circumstances necessitating or preceding the order for and administration of PRNs and patients' responses to PRN medications are not documented in the patients' charts. For example, T.N. received a PRN medication in May 2005. However, the treating psychiatrist was unaware of the fact that a PRN medication had been administered, as evidenced by the lack of any reference to the PRN medication in his progress notes. Nowhere in the chart was there any documentation of the circumstances necessitating the PRN order, or of the patient's response to the PRN.

In addition, although St. Es has a policy governing the use of PRN medication, it does not follow the policy. According to the policy, PRN orders are to be renewed, if at all, every 72 hours. Not only are physicians not reviewing and renewing the PRN orders every 72 hours, the nursing staff are administering PRN medications contrary to policy and based on outdated orders. For example, on June 17, 2005, a patient was given PRN medications based on a PRN order from June 8, 2005. Moreover, oftentimes, PRN orders are not dated. For example, U.Y. had a PRN order for three different medications but the physician did not date the order. When the order was transcribed by the RN on June 8, 2005, the RN arbitrarily listed the start date as June 9 and the stop date as July 13 for the PRN medications. Accordingly, PRNs continue to be used and administered for several days, and oftentimes weeks, without any review or assessment.

### 3. Risk Management

In order to ensure that patients are provided a reasonably safe environment, generally accepted professional standards mandate that facilities such as St. Es maintain an effective incident management system, including mechanisms for reporting; investigating; tracking and trending; and identifying and monitoring implementation of appropriate corrective and

preventative action. St. Es' incident management system substantially departs from these generally accepted standards in several ways and exposes its patients to actual and potential harm.

Although it is St. Es' policy for reports to be completed after every significant incident, there is rarely any follow-up or analysis. There is no systemic review of patterns or trends of incidents that expose patients to repeated harm and exposure to harm. For example, there were three separate unusual incident reports ("UIRs") for L.P. over the course of two weeks in February 2005, stating that he was "observed lying on the floor," "observed with dried blood above his right eyebrow," and "observed on the floor w/ (what may be seizure-like activity)." There is no indication that the cause of L.P.'s injuries over the course of two weeks were ever analyzed, let alone addressed through a corrective or preventative action plan. Similarly, over the course of one month, P.I. had three seizures. After a serious seizure on January 18, 2005, he was sent to the emergency room. On February 14, he was "found on the floor" in his bedroom and "appeared to be having a seizure" and on February 22, he was "noted getting up from the floor" and that he didn't recall what had happened. All of these reports fail to address this patient's risk of seizures and there is no indication that St. Es took any actions to address the significant risks to this patient's repeated seizures and resulting falls.

The incident reports also do not consistently provide accurate data for purposes of risk management. For example, even the most rudimentary risk management system should track the circumstances that caused a hospital patient to require care in an emergency room. In analyzing emergency room visits, a properly functioning risk management system would work to minimize the risk of need for emergency room care in the future. In the above example regarding P.I., there were two reports completed for his seizure on January 18. Neither report indicates the appropriate incident code for emergency room, although he was transported to the emergency room for a serious medical condition. St. Es' failure to properly report and record incidents makes it impossible to identify problematic trends in patient incidents and to take appropriate and timely action to address such trends and patterns. This failure exposes St. Es patients to ongoing risks of harm.

Another disturbing example of the lack of follow-up and corrective actions in response to St. Es' reports involves N.E. and S.P. S.P. reported to St. Es staff that she engaged in sex with N.E. on two different occasions on the smoking porch of

their unit. The report indicates that staff confronted N.E. about these allegations and he confirmed them. The report also stated that "[N.E.] is aware [that] he is high risk for infection related to blood born [sic] pathogens so he used condoms to prevent transmission of the blood born [sic] pathogen virus." The report goes on to state that N.E. was "counseled" regarding his potential risks to others, to have more impulse control, and less sexual preoccupation. There was no indication, however, that S.P. received any follow-up medical treatment or testing to address the potential health risks she was exposed to as a result of these incidents.

To the extent that St. Es investigates specific allegations of abuse and neglect, the investigations substantially depart from generally accepted professional standards. In the period between January 4 and May 11, 2005, 14 abuse allegations were investigated, three of which were substantiated. The investigations often fail to reconcile conflicting evidence. As a result, more often than not, allegations of abuse are unsubstantiated. In the limited cases where allegations are substantiated, programmatic or systemic issues are rarely addressed and remedies are deficient. For example, in one case where the patient's allegation was sustained, the patient alleged that three male Forensic Psychiatric Technicians had physically, sexually and verbally abused her. The investigator's findings stated "the allegations made by the patient seem to have occurred, although she may have exaggerated the degree of the abuse and the patient is afraid of the staff and what they may say or do to her for reporting these allegations." The investigator recommended reassignment of the staff to another forensic unit and training. Although it is unclear which allegations "seem[ed] to have occurred," if sexual and physical abuse indeed occurred to the patient, at any level, it is unacceptable for the offending staff members to simply be relocated to another unit where these abuses potentially could be repeated against other patients.

Finally, as of our visit in June 2005, the Risk Manager, who is the individual responsible for conducting the abuse investigations, was recently appointed. Not only did he state that no additional abuse investigations had been conducted since his appointment several months earlier, he had not received any training in investigating abuse allegations.

### 4. Quality Assurance and Improvement

Generally accepted professional standards dictate that a hospital like St. Es develop and maintain an integrated system to monitor and assure quality of care across all aspects of care and treatment. Such a quality assurance system must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends in patient treatment. Throughout this letter, we enumerate various failures at St. Es to provide adequate care and treatment for its patients. With few exceptions, St. Es has failed to identify these problems independently, or formulate and implement remedies to address them. Consequently, actual and potential sources of harm to St. Es patients are going unaddressed.

For example, there is no indication that the numerous problems with polypharmacy,[5] as noted in more detail below in Section B.2, are being addressed. Although minutes of the Pharmacy & Therapeutics ("P&T") Committee indicate some attention to the risks of this practice, there is no documentation of any specific actions to address systemically the incidents of polypharmacy, other than bringing it to the attention of the psychiatrists. In fact, the P&T Committee January 2005 meeting minutes state that "[t]he director of psychiatric services has raised the issue at numerous psychiatrists' meetings with little improvement to date." Similarly, as outlined in more detail below, the forms utilized for medication monitoring are seriously deficient and are not, but should be, integral parts of quality assurance and improvement.

To the extent that incidents are reviewed in a systemic manner, they are reported in a quantitative manner and there is no qualitative review. For example, the Quarterly Performance Improvement Report, dated April 29, 2005, reported that there was a 41% increase in patient-to-patient altercations from the previous quarter and a 76% increase in patient falls. However, there was no further information or analysis on the causes of these marked increases of incidents. Although quantitative review is an important first step to St. Es' performance analysis, qualitative review of the data is essential to meaningful progress and improvement to the level and substance of patient care and treatment at St. Es.

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[5] Polypharmacy is the contemporaneous use of multiple medications to treat the same condition.

Similarly, the nursing department's limited number of performance indicators are quantitative rather than qualitative. A more meaningful qualitative analysis of the nursing process should be completed. For example, at present St. Es merely counts the number of hospitalizations and emergency room visits. A more detailed analysis of hospitalizations and emergency room visits is necessary. Precipitating factors that led to hospitalization, the care and treatment after returning from the hospital, and, in some instances, the reasons for repeated hospitalizations and/or death were not appropriately analyzed and reviewed for trends and patterns. The data that St. Es does collect suggests patterns of problems. For instance, the high number of hospital visits involving common but serious conditions, such as dehydration and constipation, require further review and analysis to formulate and implement remedies to adequately address their unnecessary and avoidable recurrences to St. Es patients.

**5. Environmental Health and Safety Issues**

St. Es also fails to provide patients with a safe living environment. St. Es is rife with serious environmental hazards, many of which pose risks of serious injury, illness, and death. These environmental deficiencies exacerbate the plethora of deficiencies in patient care and treatment identified throughout this letter. In a facility serving people at risk of harming themselves or others, the environment should be free of physical risks and environmental hazards. St. Es egregiously departs from this generally accepted professional standard of care.

The physical plant of St. Es is in a state of severe deterioration and serious dilapidation. As a result, St. Es' physical environment contains a number of serious health risks and safety hazards. For example, the kitchen is infested with vermin and insects, as evidenced by a considerable amount of mice droppings, cockroaches, and insects observed throughout the kitchen area, especially in food storage areas. Many of the vermin and rodent bait traps were full. Also, the kitchen garbage disposal was not working, had exposed electrical wiring, and was clogged with dirty water and food debris. The stench emitting from the garbage disposal was overwhelming. These deplorable and unsanitary conditions in the food preparation area are unacceptable and pose serious health hazards. In addition, we observed a number of patient bedrooms with bottles filled with urine, a soiled diaper placed in an open trash can, and dirty clothing piled in the corners of the rooms. Given the existing rodent and insect problems at the hospital, these conditions only exacerbate the abhorrent sanitation problem.

Because St. Es' preventative maintenance program was discontinued in 1999, reportedly due to budgetary constraints, the 150-year-old physical structure continues to deteriorate at an accelerated pace. Hospital and maintenance records reflect ongoing problems with heating, air conditioning, water temperature, and door locks. In most buildings, electrical, plumbing, heating, air conditioning, and mechanical systems are minimally functioning and require constant repair. It was also reported that many of the physical plant support systems and equipment are broken and obsolete. For example, only two of the four elevators in the forensic ward were operable at the time of our visit, and one elevator has been inoperable for over five years.

St. Es patients have a constitutional right to basic care. Youngberg, 457 U.S. at 315-16. The lack of basic care at St. Es (e.g., heat, air conditioning, plumbing and electricity) places patients at great health and safety risk. For example, during our visit on a hot day in late June, the air conditioning unit in Unit CT2-D was broken. This is particularly hazardous for patients with respiratory problems and who are bedridden. Other examples include excessively hot water temperatures for the bathroom sinks in the geriatric wards, at 140-144E Fahrenheit, exposing elderly patients to scalding water. Conversely, water temperatures for the kitchen dishwasher, at 120E Fahrenheit, were not high enough (i.e., 180-195E Fahrenheit) to sanitize utensils and dishes. Additionally, during our visit, the mechanical room of a patient-occupied building contained exposed electrical systems and equipment flooded with seven to eight feet of water. The risk of execution was palpable.

St. Es does not have an adequate fire safety and prevention program. Given the size of the campus, the existing dangerous conditions of the buildings, and the substantial potential for electrical fires, patients are exposed to serious risks of harm and death. For example, in five patient-occupied buildings, there are a number of inoperable smoke dampers.[6] In building CT-5, 23 out of 27 smoke dampers are inoperable. In the event of a fire or smoke emergency, patients would be exposed to serious risk of injury and death.

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[6] Smoke dampers restrict the spread of smoke in HVAC systems that are designed to be automatically closed down in the event of a fire or control the movement of smoke within a building when the HVAC system is operational in engineered smoke control systems.

Moreover, the last fire alarm inspections for the forensic and acute care units were completed in 2003. The 2003 inspection failed three of the ten forensic wards and found that 17 of 36 smoke detectors to be inoperable. Similarly, St. Es' fire plan, dated November 12, 1996, is seriously outdated, but more importantly, it was never approved by any competent authority or governmental agency, as required by law.

## B. PSYCHIATRIC AND PSYCHOLOGICAL CARE AND TREATMENT

Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices, or standards. Youngberg, 457 U.S. at 353; United States v. Weston, 255 F.3d 873, 876 (D.C. Cir. 2001) (citing Youngberg for establishing proposition that determination of medically appropriate course of action "obviously depends on the judgment of medical professionals."). Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions).

Generally accepted professional standards require that a patient in a mental health hospital be provided a treatment program resulting from interdisciplinary treatment planning that leads to clinically appropriate goals specific to the patient's needs and designed to support the patient's recovery and ability to sustain him or herself outside the hospital. Inadequate treatment causes harm because it fails to stabilize the patient's clinical condition, leads to the patient's further decompensation, and/or unnecessarily prolongs the institutionalization of the patient.

St. Es fails to provide its patients with adequate psychiatric and psychological care and treatment because of inadequate treatment planning and inadequate psychological and psychiatric services. Specifically, deficiencies in treatment planning include inadequate assessments and diagnoses, insufficient treatment plans, and failure to provide ongoing assessments. In addition, St. Es provides inappropriate medication management and monitoring and deficient behavioral treatment plans and programs.

### 1. Failure to Provide Adequate Treatment Planning

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 utilization 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, revising the treatment plan. In order 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 assuring that relevant and critical patient information is obtained and considered.

St. Es' treatment planning substantially departs from generally accepted professional standards. From initial diagnosis and assessment, to the skills and functioning necessary for recovery and ultimate community reintegration, St. Es' treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation needs of its patients. As a result of these deficiencies, patients' actual illnesses are not being properly assessed and diagnosed; patients are not receiving appropriate treatment; patients are exposed to potentially toxic treatments for conditions from which they do not suffer; patients are not receiving appropriate psychiatric rehabilitation; patients are at risk of self-harm and harm from other patients; patients are subject to excessive use of restrictive treatment interventions, increased risk of relapses and repeat hospitalizations; and patients' options for discharge are seriously limited resulting in unnecessary prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

**a. Inadequate Psychiatric Assessments and Diagnoses**

Adequate assessments lead to accurate diagnoses. It is axiomatic that an effective treatment plan must begin with an accurate diagnosis. An adequate assessment establishes the parameters for individualized, targeted, and appropriate interventions that meet the medical and psychological needs of the patient. Adequate assessment of a mental health patient for treatment planning purposes requires input from various disciplines, under the active direction and guidance of the treating psychiatrist.

At a minimum, an initial assessment should include: a) an adequate review of presenting symptoms and the individual's mental status; b) a provisional diagnosis and differential diagnosis; and c) a plan of care that includes specific medication and other interventions to ensure safety of the individual and others. As more information becomes available, the assessment must be updated to include: a) a history of the presenting symptoms from the individual based on the individual's level of functioning and from collateral sources, as available; b) a course of the symptoms and setting within which the symptoms occur; c) the relevant historical findings in the patient's biological, behavioral and social domains; d) a review and critical examination of diagnostic conclusions made in the past as more information becomes available; e) review of medical and neurological pathology and their impact on current status of symptoms and treatment; and f) a complete mental status examination.

Psychiatric assessments at St. Es are grossly inadequate resulting in diagnoses that are without clinical justification. For example, upon admission to St. Es in September 2003, a patient, O.L., was given two alternative diagnoses because the treating psychiatrist could not determine at the time of admission which diagnosis applied. The treating psychiatrist, however, never finished the initial assessment so the patient's diagnosis was never finalized. Two years later at the time of our visit, the psychiatrist still had not finished the initial diagnosis and was unable to provide a reason for the substantial delay. Another example of an inappropriate assessment and diagnosis involves W.P. W.P. was given two opposing diagnoses, one of which ruled out the possibility of the other. Notwithstanding the fact that a diagnosis of one type ruled out the other, his treating psychiatrist erroneously stated that both diagnoses were appropriate.

Additionally, St. Es patients are routinely given tentative and unspecified diagnoses (often referred to as "rule out" or "R/O" or "not otherwise specified" or "NOS") without evidence of further assessments or documented observations required to finalize the diagnoses. For example, A.O. was diagnosed with such an unspecified diagnosis upon her admission in October 2004. Notwithstanding this patient's repeated and increasingly assaultive behavior against other patients and unresponsiveness to her medication regimen, her treating psychiatrist still did not specify a diagnosis for more than eight months stating that he liked to "wait and see." As a result of this treating psychiatrist's failure to adequately diagnose, not only is his care contrary to generally accepted professional standards, but

it has exposed this patient and other patients to increased harm and risk of harm. In yet another example, V.B. was diagnosed with dementia NOS. Her treating psychiatrist was asked about the rationale for the diagnosis of dementia and she responded "I do not know if it is dementia or schizophrenia." Although chronic schizophrenia may be accompanied by features of a dementing illness, generally accepted standards require, at a minimum, certain criteria and a work-up to identify possible causes for a separate diagnosis of dementia NOS. When asked about these criteria, the psychiatrist said that "[the patient] has been going down hill." She was unable to specify the criteria that justify a diagnosis of dementia. When asked about any follow-up testing to delineate the type and possible causes of dementia, she said, "this woman has been here for a long time, I did not do any laboratory tests."

Our review also identified a number of psychiatric assessments conducted by medical students who have no formal psychiatric residency training, and, in some of those cases, there was no oversight or review by a supervising psychiatrist. For example, D.B. was assessed by a medical student who noted that D.B. has active delusions and hallucinations and thoughts of harming himself and others by stabbing them. There was no review by a psychiatrist for this high risk individual.

These examples demonstrate failures in the preliminary stages of assessment and diagnosis. In the vast majority of cases that we reviewed, St. Es' psychiatric assessments were inaccurate, incomplete, and uninformative. St. Es also fails to adequately review or critically examine past diagnoses or update diagnoses based on the patient's historic response to treatment. As a result, treatment interventions are not aligned with the individual's needs. Because assessment and diagnoses are the bases upon which all subsequent care, treatment and services are based, it is inevitable that a chain reaction of harmful treatments and interventions follows. St. Es' assessments and diagnoses practices grossly depart from generally accepted professional standards, and, as a result, patients experience harm and a significant risk of harm.

**b. Inadequate Psychological Assessments and Diagnoses**

Generally accepted professional standards require that before a patient's treatment plan is developed, facility psychologists must provide a thorough psychological assessment of the patient to assist the treating psychiatrist in reaching an accurate diagnosis and provide an accurate evaluation of the

patient's psychological needs. Moreover, as needed, additional psychological assessments should be performed early in the patient's hospitalization to assist with any psychiatric disorders that may need further study and/or diagnosis, such as rule out, "deferred," and "not otherwise specified" diagnoses. As with poor psychiatric assessments, inadequate psychological assessments contribute directly to improper treatment interventions, exposing patients to actual or potential harm, particularly in the area of improper medication administration. Without the adequate support of the psychologists in reviewing behavior data regarding responses to medication, psychiatrists are unable to adequately prescribe and adjust medication regimens. Furthermore, in the context of patients' needs for psychological supports and adequate life skills, harm occurs through prolonged and/or exacerbated behavioral disorders that, in turn, needlessly prolong patients' hospitalization and block their successful re-entry into the community.

Like psychiatric assessments, psychological assessments and evaluations at St. Es, with few exceptions, are also inaccurate, incomplete, and uninformative. The psychological assessments we reviewed were very brief, often consisting of only one word. They made no attempt to convey the psychological and behavioral details from the patient's history in a manner that could logically lead to specific psychological treatment interventions. In those few cases where the psychological assessments included a list of patient skills, the skills had little relevance to psychological treatment and were incapable of being translated into individualized treatment goals and psychological interventions.

Because of St. Es' inadequate psychological assessments, treatment recommendations are not individualized to patient needs and are mostly generic descriptions such as "stabilize on meds." Such grossly deficient recommendations are inadequate to formulate psychological interventions. Furthermore, rarely did the psychological assessments we reviewed recommend the development of a behavior plan, even in patients with a history of aggression or self-injury or who had been frequently subjected to seclusion and restraints.

The above problems are compounded by a lack of adequate psychological staff. There are only four clinical psychologists for the 229 civil patients at St. Es, and the only psychologist with expertise in behavioral management has substantial

administrative responsibilities.[7] This makes it virtually impossible for the current staffing of psychologists to perform their duties and responsibilities in compliance with generally accepted professional standards. Indeed, psychologists are notably absent from the treatment team process for civilly-committed patients at St. Es. Accordingly, few, if any, patient files contained evidence of adequate behavioral treatment. Psychological supports and the development of adequate life skills are commonly unaddressed. As a result, psychology services are fragmented and not integrated into overall clinical care. Patients are exposed to actual or potential harm because their behavioral disorders are prolonged and/or exacerbated and, this in turn, needlessly extends the patients' confinement in a highly restrictive environment.

Serious behavioral problems commonly found in psychiatric hospital inpatient populations were glaringly absent from patients' charts and diagnoses, such as self-injurious behavior ("SIB"), pica,[8] and polydipsia.[9] There were surprisingly few cases of SIB noted in charts or identified in discussion with unit staff, and no cases of pica or polydipsia. After a formal request for a list of St. Es patients with polydipsia, we were provided one name. This is contrary to national rates, where it is common for facilities such as St. Es to have rates of polydipsia exceeding 20% of the patient population. Accordingly, it is implausible that there was only one case at St. Es, indicating that cases are not being detected and treated.

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[7] While regulations do not provide for a specific number of psychological staff, our consultant opined that facilities such as St. Es should generally have, at a minimum, one psychologist for every unit (25-30 patients per unit); at least three full-time equivalent ("FTE") psychologists with behavioral management expertise; and two FTE neuropsychologists.

[8] Pica is a common eating disorder that is prevalent in patients with mental illness or cognitive impairment in which a person repeatedly eats non-food items.

[9] Polydipsia is a common disorder that is prevalent in chronic psychiatric inpatients, particularly those patients diagnosed with schizophrenia. This disorder causes a person to feel constantly thirsty and to seek to drink excessive amounts of water. It may cause incontinence, vomiting, seizures, and/or water intoxication, and even death.

Finally, St. Es' psychologists fail to adequately assess and monitor patients for behavioral responses to their medication regimen, particularly those patients on multiple medications for whom continued monitoring and evaluation is critical to treatment success. An essential role of psychologists in hospitals such as St. Es is to design and monitor interventions for patients with behavioral problems, including monitoring behavioral responses to medications. The psychologist should be assisting the psychiatrist in the appropriate use of polypharmacy and dosing requirements in developing and updating a patient's treatment plan. Unfortunately, at St. Es, the psychologists fail to adequately review behavioral data or a patient's response to a particular pharmacological intervention. The few reviews we did discover included serious flaws that invalidated their clinical conclusions. Consequently, St. Es generally fails to document a rationale for the prescribed medications and, oftentimes, there is an inadequate correlation between diagnosis and the prescribed medication.

As a result of inadequate psychological assessments, diagnoses, and monitoring of behavioral data to support proper medication regimens, patients at St. Es are subject to harm through unnecessary and often toxic polypharmacy. We found numerous examples where medications are used in lieu of behavioral treatment, often without benefits. For example, N.P.'s treating psychiatrist acknowledged in a treatment plan meeting that his medications were ineffective and his challenging behavior of throwing urine and feces at staff in response to hands-on care continued unabated. Although this individual is an ideal candidate for behavioral intervention, St. Es has failed to provide him with a behavioral plan. Similarly, I.C. has behavioral problems, such as chewing papers, digging through the trash, and fighting with his peers. His treatment plans fail to include behavioral interventions for these behaviors, even though these behaviors have not responded to medication.

### c. Inadequate Treatment Plans

Generally accepted professional standards mandate that adequate treatment plans: 1) integrate the individual assessments, evaluations, and diagnoses of the patient that are performed by all disciplines involved in the patient's treatment; 2) identify a patient's individualized needs; and 3) identify treatment goals and interventions related to the patient's needs in order to support the patient's recovery and ability to sustain him or herself in the most integrated, appropriate setting. Moreover, the content of the treatment planning should be person-centered, strength-based, and outcome-focused. Conversely,

treatment plans should not focus on symptom reduction and should not provide generic and/or unattainable goals and objectives.

Not only do St. Es' treatment plans lack any meaningful involvement of psychologists, when the treatment plans attempt to address behavioral issues, they are grossly deficient. They are rarely individualized and the goals and interventions are typically boilerplate and unrelated to the goal of recovery and community reintegration. For example, H.Y.'s March 31, 2005, treatment plan identifies active psychotic symptoms including auditory hallucinations, paranoid delusions, and agitation as her "first problem." However, her record indicates that she has been free from all these symptoms for several months. Accordingly, H.Y.'s hospitalization may be unduly prolonged based on a treatment plan that focuses on a need that no longer exists. Similarly, D.B.'s treatment plan lists "noncompliance with medications" as a problem. The plan, however, fails to delineate any of the factors that contribute to the non-compliance. Without this, staff are unable to intervene to help this patient with his problems. In the majority of the charts reviewed, the treatment plans merely repeated some manifestation of the mental illness such as "non-compliance with medication," and many of the issues identified in the plans were no longer active but already resolved. The plans failed to address specific skills required to mitigate the impairments that underlie or accompany the illness. This is a substantial departure from generally accepted standards.

In addition, treatment plans at St. Es incorporate goals and objectives that are not related to the actual needs of the patients, not achievable, and/or not measurable or specific. For example, O.L.'s short-term goal stated "patient will take medications." However, the record indicated that during this same time frame she was "cooperative" and, in fact, one of her strengths listed that she "accepts her medications." It is inexplicable how O.L.'s strength is also her problem. In another example, F.T.'s treatment plan says both that the patient recently exhibited assaultive behavior towards another patient and that the patient has not had any altercations with other patients or staff.

Similarly, H.Y.'s October 26, 2005 treatment plan stated that her short-term goals were to "accept medications and verbalize concerns" and "attend treatment malls." During the same time frame, her strengths are listed as, "compliant with medications and takes them, attends groups." Her previous treatment plan dated February 23, 2005, stated the following goals, "avoid the influence of hallucinations and paranoid

thinking, maintain behavioral composure" and "identify, refute and understand symptoms for each condition and react to them in a constructive manner." These goals and objectives are not possible given the patient's level of functioning.

Another example of a patient with an unattainable goal is X.M. X.M. is diagnosed with dementia due to head trauma with behavioral disturbance and seizure disorder. Although his chart indicates that he has severe cognitive impairment, his short-term goal stated, "will be able to notify staff if he is having a seizure." Based on this treatment plan, X.M. will be hospitalized indefinitely. His goal is unachievable. More disturbing, X.M. also has serious problems with violence and sexually inappropriate behavior. Nevertheless, his treatment plan glaringly omits any intervention that includes a functional analysis of these behaviors and specific behavioral strategies to reduce these behaviors and to teach him appropriate skills instead. Additionally, there were no specific interventions to address his significant cognitive impairment. As a result, not only is he deprived of needed treatment with the consequence of prolonged hospitalization, but other patients are endangered.

Even when a treatment plan does identify a patient's need and specifies an intervention, the intervention is not consistently implemented as required by generally accepted professional standards. For example, V.B.'s treatment plan intervention states that "[psychiatrist] will do supportive psychotherapy, and [psychiatrist] will monitor patient's behavior and prescribe meds according[ly]." Not only are these interventions generic, not individualized and not linked to outcomes, there is no documentation that the psychiatrist or anyone else provided any of these interventions. Moreover, although V.B.'s significant cognitive and self-care deficits have been resistant to her medication regimen, they appear to be the main reason for her continued hospitalization as her treatment plan fails to include behavioral interventions to address these needs.

**d. Failure to Provide Ongoing Assessments**

Generally accepted professional standards require that psychiatric assessments continue on an ongoing basis throughout a patient's stay at a psychiatric hospital, involve timely and thorough reevaluations of behaviors targeted for treatment, and evaluate new clinical developments. Such ongoing assessments should be conducted at a frequency that reflects the individual's clinical needs, delineate the nature of behaviors targeted for

treatment, and thoroughly document clinically significant changes in the individual's condition. Furthermore, to ensure continuity of care when individuals are transferred between units, an additional psychiatric assessment should be done by the referring psychiatrist, particularly when new treatment teams take over the responsibility for providing treatment.

A.T. presents a tragic example of St. Es' failure to provide timely ongoing assessments, including assessment of important risk factors. Although his diagnoses identified his problems with impulse control, explosive conduct and antisocial behavior disorder, his assessment did not include a plan of care other than a statement that the intervention was to provide medication in order to ensure safety. In March 2004, he assaulted another patient, and the victim suffered severe head trauma resulting in a coma. The victim died in March 2005, allegedly as a result of injuries sustained during the assault. Furthermore, A.T. assaulted a second patient on November 12, 2004. During our review in June 2005, the last psychiatric note for this patient was written on December 12, 2004. Despite the significant acts of violence that this patient had engaged in recently, including an allegedly deadly act of violence, he had not been seen, let alone actively treated, by a psychiatrist in over six months. Moreover, other than an increase in his medication after the November 2004 assault, there was little, if any, reassessment and attention to the psychiatric care of this extremely high risk patient.

Moreover, although there are significant risks associated with certain medications and/or combinations of medications, there is little ongoing assessment of patients' reactions or progress on various medication trials. For example, U.B. was treated with a psychotropic drug, aripiprazole, for her psychotic illness. On April 13, 2005, the treating psychiatrist discontinued the aripiprazole and started her on another psychotropic drug, olanzapine. Approximately two days after the start of olanzapine, U.B. suffered a seizure and was sent to the emergency room for an evaluation. U.B. had no prior history of seizures. A neurology assessment later concluded that the seizure was induced by olanzapine. It appears that the psychiatrist changed the patient's medication based on a dated nursing report. The psychiatrist apparently assumed that U.B. was refusing her aripiprazole on April 13 and ordered olanzapine instead. However, according to the chart, U.B. was not refusing the prescribed aripiprazole at the time of the psychiatric note on April 13, and had in fact complied with the aripiprazole medication on April 11, 12, and 13. The report of her treatment refusal was apparently based on the fact that she had refused the

medication on April 9 and 10. Not only was the psychiatrist careless in his cursory evaluation of the patient's current status and condition, he changed her medication without weighing the risks of medication replacement which directly caused her to have a seizure.

Another example of St. Es' failure to conduct ongoing assessments of patients' reactions to medications with significant risks involves J.R. J.R. has been taking an antipsychotic drug that carries the potential for the serious side effect of tardive dyskinesia ("TD"),[10] for several years.

When his treating physician was asked about the procedure for identifying TD, he was unable to state the correct procedure to evaluate for early signs of this disorder. Furthermore, J.R.'s chart did not include any psychiatric progress notes and the last screening test for identifying TD and related disorders was dated over four years earlier.

Although patients at St. Es are routinely transferred from unit to unit, assessments are rarely completed upon transfer and the receiving units typically do not know important information about the patients' medication, illnesses, or treatments. For example, T.N. has a diagnosis of chronic paranoid schizophrenia and over a two month period, he was placed on four different units. His transfer assessments were incomplete, completed by a medical student without a psychiatrist's review and supervision, without a summary of medication trials and his response to treatment, without current targets for treatment, without a projected discharge plan, and without any rationale for or benefits of the transfers. Similarly, O.G. was placed on Unit CT2 upon admission in March 2005. He eloped a month later. When he returned, he was transferred to Unit RMB6 and a note in his chart indicated that he was "inappropriate" for Unit CT2. Yet, he was transferred back to Unit CT2 on May 3 and eloped again on May 9. A major contributing factor to the deficiencies regarding inter-unit transfers is that the units do not have distinct missions or purposes. Accordingly, patients are moved from unit to unit in an ad-hoc fashion and their distress is likely increased due to frequent readjustments to different staff and

[10] Tardive dyskinesia is a potentially irreversible movement disorder. Symptoms of tardive dyskinesia include involuntary, aimless movements of the tongue, face, mouth, jaw, or other body parts.

settings. There is a significant lack of continuity of care, and communications between the transferring and receiving treatment teams are seriously deficient.

### 2. Failure to Provide Adequate Psychiatric and Psychological Services

The provision of effective interventions for patients in care settings such as St. Es requires the integrated participation of various treatment services, the exact configuration of which is dictated by the individual patient's needs. Under generally accepted professional standards, a mental health hospital has the duty to provide adequate supports and services necessary to implement a patient's treatment plan, including providing medication treatments based upon evidence of appropriateness, safety and efficacy; implementing a monitoring system to ensure appropriate use of medications; and instituting an adequate array of relevant treatment programs to meet the specific needs of its patient population. Each of these services at St. Es substantially departs from generally accepted professional standards causing substantial harm to patients, including inadequate and counterproductive treatment, serious physiological and other side effects from inappropriate and unnecessary medications, and excessively long hospitalizations.

#### a. Inadequate Psychiatric Services

St. Es' psychiatric supports and services substantially deviate from generally accepted professional standards, potentially exposing patients to harm and significant risk of harm due to the failure to: 1) exercise adequate and appropriate medication management; and 2) monitor medication side effects.

##### i. Inappropriate Medication Management

The use of medications must always be justified by the clinical needs of a patient. Medication treatments must be informed by psychiatric and pharmacological literature and professional practice guidelines. Medication use must be part of an interdisciplinary plan of care that considers the impact of medication use on individuals' quality of life. Medication treatment must be integrated with behavioral treatment so that medications are not used in lieu of behavioral treatment, for the convenience of the staff, or as punishment. There must be a documented rationale for medication use based on clinical and empirical criteria, including diagnosis, presenting symptoms,

history of response to previous treatments, and the specific risks and benefits of chosen treatments. Finally, practitioners must be alert to avoid polypharmacy, where appropriate.

St. Es fails to meet every one of the above standards of professional care. First, medications are not prescribed as an integral part of treatment plans. Treatment plans typically contain generic and standardized references to the use of medications without specification of the indications for use, target behaviors, rationale, or a risk/benefit analysis. For example, A.O.'s treating psychiatrist was unaware that A.O. had gained over 55 pounds in five months and failed to acknowledge that weight gain was a risk factor associated with the medication the psychiatrist had prescribed.

Patients' complex medication treatments are often continued with little to no observation of the effects on the patients or review of the risks and harms for prolonged medication regimens and polypharmacy. For example, M.K. is diagnosed with a psychotic illness and mild mental retardation. His current medication regimen consists of a number of antipsychotic medications. Although his records for the past year indicate that his psychotic symptoms have stabilized and he has been active in day program activities off campus, his treating psychiatrist could not rationalize the current need for antipsychotic polypharmacy or the need for long-term treatment with certain prescribed antipsychotic medications. Equally, if not more disturbing, is that the psychiatrist could not identify the risks of further cognitive deterioration associated with the particular antipsychotic treatments prescribed, especially in such an individual diagnosed with mild mental retardation. It is professionally well-known that the side-effects for the benzodiazepines[11] and anticholinergic agents[12] he prescribed include exacerbating cognitive decline and a high potential for addiction. Thus, M.K.'s hospitalization and complex and potentially life-threatening medication regimen may be unnecessarily prolonged based on outdated symptoms.

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[11] Benzodiazepines are medicines that help relieve nervousness, tension, and other symptoms by slowing the central nervous system.

[12] Anticholinergic agents are drugs that block the action of acetylcholine. Acetylcholine is a neurotransmitter--a chemical messenger that helps nerve cells communicate.

Z.T. is another example of a patient who suffered harm as a result of St. Es' gross departure from professional standards. He is diagnosed with schizoaffective disorder, alcohol abuse and cognitive disorder NOS. As of November 2004, his medication regimen consisted of a number of psychotropic drugs: haloperidol, quetiapine, benztropine mesylate, doxepin, trazodone and diphenhydramine. There was no documentation to justify or address the risks of long-term continuous use of three psychotropic medications (i.e., doxepin, benztropine mesylate and diphenhydramine) with significant anticholinergic effects,[13] serious risk factors for an individual with cognitive impairment. In January 2005, treatment with another psychotropic drug, clonazepam, was added, which increases risks for cognitive decline, falls and addiction, again without justification or documentation of the added risks for an individual diagnosed with cognitive impairment and alcohol abuse. On January 10, 2005, he was noted to be "more confused than usual, drowsy and unsteady" along with a notation that Klonopin [clonazepam] was probably contributing to confusion and that another psychotropic drug, Depakote [divalproex], was to be added to "decrease agitation." There was no documentation of why the added treatment for "agitation" was necessary if he was described to be "drowsy." Subsequently, conflicting orders regarding the use of clonazepam were written in the chart: January 10 to discontinue clonazepam and January 13 to continue clonazepam. As of January 13, 2005, the individual was still receiving a regimen of a number of psychotropic medications (i.e., haloperidol, quetiapine, doxepin, and clonazepam) in addition to a new psychotropic drug, amantadine, which replaced benztropine. There was no documentation of target symptoms to explain the change of treatment to amantadine. On January 17, 2005, a UIR was completed to document that he was observed with "unsteady gait" and suffered a fall. His overall medication management illustrates St. Es' failures in timely evaluation, proper and proactive assessments of the risks and benefits of treatment, and attention to high-risk and unjustified use of certain classes and dangerous combinations of medications for individuals at risk. Moreover, not even an incident report triggered a much-needed evaluation.

A tragic example of a patient who may have died as a result of St. Es' gross departures from professional standards is C.O. C.O. was diagnosed with schizophrenia, undifferentiated type, chronic obstructive lung disease, lactose intolerance, chronic

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[13] Anticholinergic effects include confusion, blurred vision, constipation, dry mouth, light-headedness, difficulty starting and continuing to urinate, and loss of bladder control.

constipation, and a seizure disorder. His medication regimen included a number of psychotropic drugs (i.e., ziprasidone, haldol, benztropine mesylate, lorazepam and divalproex). On April 27, 2005, he collapsed in the shower and was admitted to the intensive care unit at Greater Southeast Community Hospital. He suffered cardiac arrest and died two days later. Although C.O.'s records do not provide the exact cause of death, the mortality review indicated likely cause of death to include cardiac arrhythmia secondary to prolonged QT interval.[14]

There were numerous instances of grossly inadequate care provided to this patient. First, the patient's ziprasidone, a medication known to have potentially life-threatening risks of cardiac arrhythmia, was initiated and later increased without any assessments or EKG monitoring during the initiation or upward titration[15] of the medication. Five months later, the chart indicated that an EKG was eventually performed and that it showed abnormalities, including a prolongation of the QT interval of more than 500 msec. A prolongation of the QT interval of more than 500 msec is an absolute contraindication of ziprasidone treatment. In fact, concomitant treatment with agents that can further prolong the QT interval, such as haloperidol, which this patient was also taking, is another contraindication to treatment with ziprasidone. Moreover, C.O. was also treated with benztropine mesylate despite its risk factor for causing constipation, a condition for which this patient was not routinely monitored and for which he was hospitalized on numerous occasions. Finally, notwithstanding the fact that he should have been taken off of ziprasidone altogether after the EKG results, he was not subsequently regularly monitored or assessed for the increased risks while he was continued on the treatment. This case is an example of St. Es' egregious departure from basic standards of care that quite possibly played a significant factor in this patient's death.

**ii. Inadequate Medication Monitoring**

Generally accepted professional standards require that facilities such as St. Es adopt and incorporate the necessary protections and safeguards to ensure that patients are afforded safe and effective pharmacological treatment. Hospitals such as

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[14] A prolonged QT interval is the measure of delay between heartbeats.

[15] Titration is a method or the process of determining the appropriate concentration of the medication in the smallest amount to be effective.

St. Es must have mechanisms to: 1) monitor practitioners' adherence to specific and current guidelines in the use of each medication; 2) report and analyze adverse drug reactions; and 3) report, analyze, and document actual and potential variations in the prescription, transcription, procurement/storage, dispensing, administration, and documentation categories of medication. To the extent that these mechanisms even exist at St. Es, they are grossly deficient.

St. Es fails to provide any systematic monitoring to ensure appropriate, safe, and effective medication use in the facility. St. Es' current system of monitoring antipsychotic polypharmacy utilizes a standard of three or more antipsychotic medications instead of the generally accepted standard of two or more medications of the same class.

St. Es' Pharmacy and Therapeutics ("P&T") Committee, which is responsible for monitoring medication use, also does not adequately perform its necessary functions. The P&T Committee performs superficial review of medication uses and does not implement meaningful corrective actions when problems are indicated. The P&T Committee also fails to perform evaluations of the utilization of medications as required under an adequate monitoring system.

Furthermore, St. Es' medication guidelines, which are the basis of any effective medication monitoring system, are seriously deficient. With the exception of clozapine, St. Es does not have any guidelines on the use of psychotropic medications, including those with serious potential side effects. Furthermore, the guidelines for clozapine are outdated. They fail to provide necessary monitoring requirements for a variety of risks, including metabolic effects and the potentially life threatening risk of myocarditis,[16] and deleterious drug interactions with anticonvulsants, diets, and tobacco smoking.

St. Es' current system to track and analyze adverse drug reactions also has a number of deficiencies, including serious under-reporting. The data collection tool is incomplete because it does not include basic components, such as a definition of an adverse drug reaction, a severity scale, a probability scale, or a description of patient outcome. There are no established thresholds by which cases of serious drug reactions are analyzed or that such analysis takes place at all. There is no data analysis to indicate individual or group practitioner trends.

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[16] Myocarditis is the inflammation of the heart muscle, a known side effect from the use of clozapine.

And, there is no evidence that any data on adverse drug reactions have been used for performance improvement activities.

Similarly, St. Es fails to provide adequate protection against medication errors. For example, the current system ignores a number of substantial variances, such as procurement and storage, monitoring, and documentation. It does not incorporate information or analysis regarding critical breakdown points or individual or group practitioner trends. Finally, it does not appear that variance data have been used for performance improvement activities and there is no evidence of any meaningful corrective actions as a result of variance analysis.

Finally, it is apparent that St. Es patients are not accurately monitored for the risk of TD. Generally, St. Es' psychiatrists are not sufficiently knowledgeable regarding the identification and monitoring of TD. Moreover, nursing staff do not document any monitoring of TD. In addition, contrary to generally accepted standards, baseline and periodic assessments utilizing a validated rating instrument, such as AIMS, are either never conducted or have not been conducted for several years. In fact, psychiatrists appear to be confused as to the medications that are associated with TD side effects. For example, when T.N.'s psychiatrist was asked about the risks and benefits of his continued treatment with benztropine mesylate, a medication professionally well-known to be detrimental for patients with TD because it masks TD symptoms, he erroneously stated that the medication prevents TD.

**b. Inadequate Psychological Services**

In a mental health hospital, generally accepted professional standards require that every patient be provided with a rehabilitative treatment plan. The plan must be devised to improve the patient's ability to engage in more independent life functions, so as to better manage the consequences of psychiatric distress once the patient is discharged from the hospital. To be effective, these interventions should address the patient's needs, build on the patient's existing strengths, and be clearly organized in an individualized treatment plan. Moreover, if a patient has a behavioral issue, the patients' treatment plan should include a behavioral treatment plan designed to promote and facilitate skills development and address the behavioral issue. Adequate behavioral treatment plans should contain the following minimum information: 1) a description of the maladaptive behavior; 2) an analysis of why the patient is having the maladaptive behavior and the competitive adaptive behavior that is to replace the maladaptive behavior; and 3) documentation

of how reinforcers for the patient were chosen and what input the patient had in the development of such reinforcers along with the system for earning the reinforcers.

**i. Inadequate Behavioral Treatment Plans**

Except for a few patients on the forensic units, St. Es patients who need behavioral treatment plans are not provided with them. This is a substantial departure from generally accepted professional standards, and not surprising given the limited number of psychologists for the civil patients. It is also dangerous.

A significant number of patients at St. Es exhibit dangerous or difficult behaviors, such as self-injurious behavior and aggressive acting out. Very few, if any, have individual behavioral treatment plans. In fact, staff appear to temporarily manage and react to dangerous or difficult behaviors instead of implementing a plan to identify factors and precursors that contribute to these types of behaviors. As a result, patients who repeatedly act out or exhibit dangerous behaviors are continuously placed on PRN medications and/or placed in seclusion and/or restraints after the offending behaviors. For example, B.E. is diagnosed with a personality disorder and a cognitive disorder due to head trauma. Although he frequently hits or attempts to hit others, hits or attempts to hit his head on the wall, continually wears a helmet, and is frequently on one-to-one supervision, his treatment team has failed to assess his risky behaviors; failed to analyze behavioral, environmental, cultural or other factors that contribute to the risk; and failed to identify any supports to protect B.E. or others from his risky behaviors. His treatment plans fail to include needed behavioral interventions to address the ongoing risk. In another example, I.R. has been noted to be "belligerent, aggressive, and non-compliant with medication." She does not have a behavioral treatment plan for her aggressive behavior. Her treatment plan merely identifies "supportive psychotherapy and medication" as the necessary interventions. Because I.R. is cognitively impaired and has difficulty with attention, memory, reasoning, and the capacity for self-reflection, supportive psychotherapy is an ineffective strategy.

A number of St. Es patients are incontinent of urine and/or feces. Although there are some appropriate behavioral treatment plans for patients with these problems on the forensic units, we could not identify a single example of an adequate behavioral treatment plan on the civil units. We observed some patients wearing adult diapers and others simply walking around smelling

of urine. For a number of patients, incontinence is not even identified as a targeted problem. For example, V.B. is incontinent of both urine and feces and has significant cognitive impairment and limited verbalization. St. Es has failed to provide V.B. with a behavioral treatment plan for any of these significant issues. Each is a barrier to this patient being discharged from St. Es.

To the extent behavioral treatment interventions are identified for patients with incontinence, they are vague and inadequate to reduce or eliminate these behaviors. For example, U.N. was noted as incapable of "toileting" and his behavioral treatment plan is to "encourage him." This plan is wholly insufficient to address his significant behavior problem.

**ii. Inadequate Behavioral Treatment Programs**

St. Es has made a significant and commendable effort to provide behavioral treatment programs for its civil patients through the establishment and development of its treatment mall and unit mini-malls.[17] The malls provide various programs, such as skill development, cognitive development, substance abuse and addiction programs for patients with dual diagnoses, psychosocial rehabilitation, geriatric programs, and restorative care and recovery. Patients are referred by their treatment teams to attend specific programs. Once a patient is assigned a program, she is given a schedule of groups to attend each day. The core groups include mental health and physical health, medication skills, social skills, community living skills, and coping skills. The elective groups include leisure activity skills, art therapy, dance therapy, creative writing, computer literacy, pet management, and merchandising. The principle of the malls is for patients to obtain targeted treatment through the mall programs consistent with their individualized treatment plans.[18] The

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[17] The treatment mall at St. Es is a separate building that provides various treatment modules, programs and services. Patients typically leave their units and attend the treatment mall on a daily basis during the week. Some units provide mini-malls on the units to accommodate patients who cannot leave their units.

[18] The forensic unit treatment malls have not yet been fully developed. In the meantime, a number of forensic patients are taken to the civil treatment malls and some groups and activities are conducted on the forensic units. The majority of patients who are on the forensic units have been adjudicated Not Guilty By Reason of Insanity. They, therefore, are in the

ultimate goal for all of the programs provided in the mall is, of course, discharge from the hospital back to the community.

Unfortunately, the mall programs to which St. Es patients are sent have very little connection to patients' treatment plans. Referral forms are intended to be completed for all patients and should identify the goals and recommended mall programs. A patient's referral to a specific mall program should be, but is not, justified by and connected to the patient's course of treatment. Instead, the referrals are vague and overly general. For example, G.H.'s referral stated that the purpose of the referral was to "develop and improve social skills." Another patient's referral stated that he "can benefit from group therapy" (E.O.). These bases for referring patients to the mall are not connected to their treatment plans. Furthermore, patients' progress, participation, or lack thereof, during treatment mall activities are not routinely recorded or reported in a way to inform treatment planning.

In many cases, patients appear to be assigned to treatment mall programs for no clinical reason. For example, the Restorative Care, Geriatric-Mall, and Recovery Road programs are intended for fragile, immobile, and/or medically compromised patients. We observed patients who were in the Restorative Care program, which provides limited and basic programming regarding sensory tasks and activities of daily living, who did not have these problems. As a result, these patients were not receiving treatment that is relevant to their skills and needs.

Patients, either because of medical or behavioral reasons, who cannot leave their units to attend mall programming are not provided any meaningful treatment alternatives. As a result, these severely ill patients are maintained with no reasonable expectation of change. Further, there are a number of patients who should be in nursing homes or housed on specialty units where trained staff can meet the unique medical needs of this subpopulation. For example, although V.B. and T.U. were identified by St. Es' staff as patients who should be in nursing homes, there were no plans for their transfer to a nursing home.

In general, St. Es' mall programs rarely match their stated purpose or they are ineffective programs for the patients who have been assigned to them. For example, many groups consisted of lectures by therapists or abstract discussion groups, which

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hospital for long periods of time. An effective treatment mall should be developed and implemented for forensic patients, so that they can learn the skills necessary for legal discharge.

are inappropriate strategies for a number of St. Es patients who have significant cognitive impairment. In addition, most groups in the cognitive/skill development program offered only arts and crafts activities that are not commensurate with the skill levels of the patients attending them. The horticulture group involved potting plants, but we observed that most of the work was completed by the staff for the patients. This is a substantial departure from the generally accepted professional standards. Those standards require clear instructions, demonstration of the desired behavior, and the patient practicing the behaviors, followed by further instruction and positive reinforcements (e.g., tokens, points, or praise).

## C. NURSING CARE AND TREATMENT

Generally accepted professional standards require nursing staff to: 1) accurately and routinely monitor, document, and report patients' symptoms; 2) actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions; 3) properly document and monitor the administration of medications; and 4) ensure adequate infection control procedures. Nursing staff are typically the first responders to patients' medical needs and serve to provide crucial and timely information to clinicians and other providers. St. Es' nursing services substantially depart from these standards, thereby exposing patients to harm and a significant risk of harm.

### 1. Monitoring, Documenting and Reporting Patients' Symptoms

Psychiatrists who prescribe medications and psychologists and therapists who oversee therapeutic interventions must rely upon nursing and other unit staff to document and report symptomology. Nursing staff have an obligation to monitor and record patients' problems and symptoms adequately. Without such information from nursing staff, the treatment teams cannot properly review and modify, if necessary, patients' treatment plans. For example, patient U.Y. has a history of becoming assaultive or violent towards himself or others if he is denied PRN medication. In one instance, he had to be placed in wristlet and anklet restraints because he became agitated when he was told that his PRN Tylenol was not on the unit and staff had to go to another unit to retrieve it. In another instance, he requested his PRN klonopin and was told that the nurse would have to retrieve the medication from another unit. The patient hit the glass door with his fist and had to be restrained. Although this

patient has a history of assaultiveness and agitation as a result of having to wait for his PRN medications, nursing staff failed to include this information in his chart. More disturbing, the patient's reaction to denial of a PRN medication was not incorporated into his treatment planning.

Basic nursing practices, such as monitoring vital signs, weight, and temperature, are largely absent from patient care at St. Es. The harm that results from these grossly deficient practices is not hypothetical.

In a seven month time span from January 8, 2005 through July 26, 2005, 44 St. Es patients needed to be admitted to the hospital. Thirty-eight of these patients were admitted through the emergency room. In other words, the great majority of hospitalized patients developed medical conditions at St. Es so severe and life-threatening that they required immediate emergency care. Four of the six patients admitted directly to the hospital were admitted for avoidable and preventable conditions, such as dehydration. A number of patients are sent to the hospital from St. Es suffering from dehydration. Nursing progress notes rarely, if ever, address basic nurse indicators for monitoring dehydration, such as weight; intake and output; skin turgor; and temperature.

Moreover, patients who return to St. Es from a hospital admission or emergency room visit, or patients who have high-risk medical conditions, receive deficient care and monitoring. For example, D.S. had a stroke on January 31, 2005 and was sent to the hospital. Upon his return to St. Es on February 2, 2005, there was no documented evaluation by the physician or any other clinical staff. Nurses failed to notify the physician when the patient had difficulty swallowing for several days. Vital signs were not monitored until 18 days later, on February 20, when the patient was readmitted to the hospital. The patient died a day later. It is inexcusable that St. Es did not provide this patient with basic medical care and monitoring, including routine monitoring of this patient's vital signs, for more than two weeks.

Several patients who returned to St. Es from the hospital, either from emergency care or from general hospital care, died shortly after their return. Upon returning to St. Es, these patients were provided little to no medical attention. For example, St. Es sent 79-year-old patient P.T. to the hospital on March 29, 2005, where he was diagnosed with congestive heart failure. He returned to St. Es approximately four days later. Contrary to generally accepted professional standards, St. Es'

physician did not see the patient until two days after his return from the hospital, when the physician had to see the patient to remove a fecal impaction. The patient died later that day. Although the cause of death is unclear based on the documentation that we were provided, the fact that the patient suffered from fecal impaction indicates that routine assessments were not completed. Assessment of bowel and bladder functioning is not only a crucial and standard nursing practice for patients recently returning from a hospital admission, but it is particularly significant in elderly patients.

Finally, a significant number of St. Es patients are seriously overweight; these problems either developed while at St. Es or were a problem prior to admission and exacerbated while at St. Es. Weight gain is a common and serious side effect for a number of medications typically used in mental health hospitals. Therefore, weight gain requires close monitoring and adjustment, if necessary. Weight and obesity at St. Es are rarely monitored, addressed, or treated. For example, although E.W.'s chart listed obesity as a problem area, there was no adequate plan to control his food consumption and he gained 54 pounds over a short period of time. Contrary to generally accepted professional nursing standards of care, nurses failed to enter a nursing diagnosis in any chart that we reviewed when there was a notable weight alteration.

### 2. Medication Administration

Generally accepted professional standards require that staff properly complete the Medication Administration Records ("MARs"). MARs list the current medications, dosages, routes, and times that medications are to be administered. Generally accepted professional standards also dictate that staff sign the MARs at the time the medication is administered. Completing the MARs properly is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug effects. If staff members fail to document the medications they are administering, it may result in patients not receiving medications or receiving medications multiple times.

We identified many instances in which staff failed to sign the MARs for medications that reportedly had been administered. For example, U.Y. was given a PRN of haldol and benadryl but they were not charted in the MAR. This is a very dangerous practice because if this patient had continued to be agitated, another nurse could have given him a repeat dosage of the PRN medication because the MAR was not accurately completed.

It is also necessary to document in the progress notes the behavior or circumstances precipitating administration of PRN medication, but these are frequently undocumented. For example, M.I. received PRN for two psychotropic medications, ativan and benadryl, on June 16, 2005, but there was no indication in the progress notes or elsewhere why this PRN medication was given.

Moreover, generally accepted professional standards dictate that nursing staff who administer medication know: 1) what the medication is for; 2) the correct dosage of a prescribed medication and to bring the dosage to the attention of the physician if the dosage is not within acceptable parameters; 3) the medication's expected results and timing; 4) the medication's negative side effects and contraindications; and 5) the symptoms of the disorder that it is targeting. We identified several instances where the nursing staff failed to apply and utilize their skills and knowledge to prevent avoidable and unnecessary harm to patients. For example, in the first five months of 2005, there were three cases of abuse brought against physicians involving the dosing of medications that were sustained. In each case, nursing staff should have also been, but were not, counseled or trained regarding proper dosing. Similarly, one RN inaccurately transcribed a physician's order as 900 mg of seroquel, when it should have only been 200 mg. The patient received several incorrect dosages of seroquel, an extremely potent psychotropic drug. The nurse should have known the acceptable dosing parameters for this medication.

The inadequate nursing care of patients at St. Es is exacerbated by inadequate numbers of nursing staff. Generally accepted professional standards require sufficient and minimum staffing to provide a level of nursing care that, at a minimum, protects patients from harm, ensures adequate and appropriate treatment, and prevents unnecessary and prolonged institutionalization. St. Es routinely compromises its patients' care and treatment by consistently providing insufficient nursing staffing levels on all of its wards and units. For example, Registered Nurses ("RNs"), who serve as the highest skilled and licensed nursing staff at St. Es, are required to supervise Licensed Practical Nurses ("LPNs"), Psychiatric Nurses Aides ("PNAs"), and the Forensic Psychiatric Technicians ("FPTs") (collectively referred to as "nursing staff"). But, RNs are routinely required to cover more than one unit at a time and, on many shifts, are altogether absent from the unit staffing levels. Consequently, FPTs, who are unlicensed and the least educated nursing staff, are routinely left unsupervised and are the only nursing staff on the units. Already substandard care becomes increasingly dangerous when FPTs are also left to administer

medications unsupervised. For example, on the June 10, 2005, evening shift of JHP Unit 3, we observed an FPT, who had worked the day shift and was now working overtime on the evening shift, administering medications without any supervision.

St. Es provides deficient nursing coverage even though it utilizes an exorbitant number of overtime nursing hours. This is particularly dangerous because RNs who work multiple and continuous shifts in a given day and week are more likely to be fatigued, less capable of making accurate clinical decisions, more likely to make medication errors, more likely to be injured and cause injuries, and less inclined to provide patients active treatment and interventions. For example, during the week of June 5, one RN at St. Es, in addition to working five regular day shifts, worked an additional eight shifts of overtime, for a total of thirteen shifts in one week.

St. Es' staffing shortages are egregious and fall dangerously below the minimum levels required to provide basic levels of nursing services and care. St. Es is understaffed by 68 RNs.[19] As discussed throughout this letter (e.g., assaults, elopements, suicide attempts, sexual activity, and poor nursing care), St. Es patients are harmed or at substantial risk of harm in a number of ways when staff are limited. Some additional examples illustrate the harms caused to patients, apparently due to staffing shortages:

On April 10, N.U. was "found lying on the floor" of her bedroom. Her breathing was shallow and she was unresponsive. She was sent to the emergency room. She was later returned to St. Es, and the next day, on April 11, she was again "found lying on the porch" unresponsive and appeared to be having a seizure. She was again sent to the emergency room. She again returned to St. Es, and the following day, on April 12, she was again "observed" in the day room as unresponsive and she was administered oxygen and transported to the emergency room. She returned to St. Es and two days later, on April 14, she was walking in the hallway at St. Es when she collapsed and became unresponsive. She was, again, sent to the emergency room. Over the course of five days, this patient was sent to the emergency room four times. Patients who return to St. Es after an emergency room visit, let alone three emergency room visits, are medically compromised and must be actively monitored. N.U. was repeatedly "found" or "observed" to be unresponsive even

[19] This number was determined based on St. Es' minimum staffing standards for direct care nurses and factoring in sick leave, annual leave, and days off.

following her return from the emergency room. St. Es repeatedly failed to actively monitor a high risk patient.

In another example, over the course of two weeks, L.P. was twice found lying on the floor injured. On one occasion he was found on the floor with dried blood above his eyebrow and abrasions after apparently suffering from a seizure and falling. On the other occasion he was, once again, "observed" lying on the floor in front of the nurse's station with abrasions to his forehead. It is inconceivable how a patient can suffer a seizure in front of the nurse's station without being observed or fall on the ground and bleed with enough time for the blood to dry before he is "observed" on the floor by any staff.

### 3. Infection Control

Generally accepted professional standards require adequate infection control. St. Es does not have an infection control program and it did not have an infection control coordinator from October 2004 to July 2005. The lack of an infection control program places the patients at risk for harm.

Areas throughout the facility and patients, themselves, had strong smells of urine and excrement. This is a potential indication that patients had been sitting in their urine or feces for a long period of time, placing them at high risk for skin breakdown and infection. Several bathrooms did not have hand soap, thereby preventing basic universal precautions such as handwashing. Many bathrooms did not have toilet paper; staff have to provide toilet paper to patients upon request. There is no clinical reason for not having toilet paper in the bathrooms. Moreover, during water main breaks, which is reportedly not an infrequent occurrence, patients must lift heavy bottles of water to flush the toilets.

## D. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING

Within the limitations of court-imposed confinement, federal law requires that hospital administration actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with patients' needs. Olmstead v. L.C., 527 U.S. 581 (1991).[20] From the time of admission, the

[20] In February 1974, a class of individuals civilly committed to St. Es filed a lawsuit against the federal government (which operated St. Es at the time) and the District of Columbia (which was responsible for community mental health

factors that likely will foster viable discharge for a particular patient should be identified expressly, through professional assessments, and should drive treatment interventions. Without clear and purposeful identification of these factors or issues to be addressed, the individual is denied rehabilitation and other services and supports to assist the patient in acquiring, developing or enhancing the skills necessary to function in a community setting.

Preparation for discharge while in the hospital appears to be almost nonexistent. In no instance could we determine that a treatment team actually had prepared a patient to transition to, or succeed in, a new setting. In fact, the provision of transition supports were almost never discussed in the numerous patient records that we reviewed. Rehabilitation goals and functional recovery were rarely identified. Expressed and demonstrated skills in work, school, or independent living were rarely analyzed. Finally, the patient played virtually no significant role in the discharge process.

Although there are no designated "discharge units" at St. Es, Units CT2C and CT2D appear to serve as discharge units because they are units with fewer restrictions and structured for patients who are higher functioning. However, unlike typical discharge units, St. Es patients appear to remain on these units for extended stays. Patients on Units CT2C and CT2D have treatment plans that include interventions with little, if any, likelihood of success, thereby preventing discharge and community reintegration. For example, R.F. is reportedly selectively mute and refuses medication and blood work, but there are no plans to modify these behavioral problems. Similarly, Q.P.'s goals are to avoid the influence of hallucinations and delusions. Although

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centers in the District). Dixon v. Williams, No. 74-285 (D.D.C. filed Feb. 14, 1974). The class action, which was filed under a D.C. statute, alleged that the defendants had failed to fulfill their duty to return patients at St. Es to the community as soon as possible and insofar as possible. The class sought community-based mental health treatment alternatives under the least restrictive conditions necessary. We are fully aware of the existence of the Dixon litigation and the ongoing efforts to address community integration of St. Es patients in the context of that case. Nevertheless, federal law also requires us to address the issue of placement in the most integrated, appropriate setting. Moreover, our review discusses the actual barriers and deficiencies of St. Es' procedures, services, and treatment for ensuring that individuals can be successfully discharged into the community.

these types of problems might be successfully addressed and reduced through a systematic course of cognitive behavioral therapy, no such plan was present.

To the extent that St. Es has discharge plans, they are overly general, non-specific, unattainable and/or irrelevant to discharge. For example, it is common for discharge goals to state "increase awareness of illness" and "reduce psychotic symptoms." These goals are not necessarily prerequisites to successful functioning and living in the community. More relevant treatment targets for community functioning, such as improving poor daily living skills, reducing aggressive acting out, and eliminating incontinence are routinely ignored in discharge planning.

It is also important to note that when patients are discharged from St. Es, they are ill-equipped to succeed in community placement. St. Es does not appear to provide any programs to prepare patients to return to the community, such as regular visits to community residences or training in skills such as shopping, laundry, and self-medication. In fact, there appears to be little attention paid to the successful transition of patients to community placements. This is illustrated by a particularly disturbing example involving patient B.E. During our visit, B.E. was scheduled to be discharged at the end of the week. While at St. Es, and, for at least six months prior to our visit, he wore a helmet, ostensibly to protect himself from self-injurious behavior; he was on one-to-one observation for the majority of the time; his bed was wheeled into the day room at night to be observed by night staff; and his bed was fitted with wrist restraints and a urinal. Thus, it is hard to understand how this patient was to be safely discharged to a less intensive outpatient environment, when he was hospitalized under such extreme and continuous restrictions.

St. Es' failure to provide adequate, individualized discharge planning significantly deviates from generally accepted professional standards and contributes to unnecessarily prolonged hospitalization and to inappropriate, unsuccessful placements in the community. As a consequence, patients are harmed or exposed to the risk of harm by the effects of prolonged institutionalization and by being denied a reasonable opportunity to live successfully in the most integrated, appropriate setting.

## III. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed and to protect the constitutional and federal statutory rights of the patients at St. Elizabeths Hospital, the District of Columbia should promptly implement the minimum remedial measures set forth below:

### A. PROTECTION FROM HARM

#### 1. Risk Management

St. Es should provide its patients with a safe and humane environment and adequately protect them from harm. At a minimum, St. Es should:

a. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards. At a minimum, St. Es should:

1. 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 seclusion and restraint, and elopements;

2. require all staff to complete successfully competency-based training in the revised reporting requirements;

3. create or revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including seclusion and restraint data, and ensure that appropriate corrective actions are identified and implemented in response to problematic trends;

4. create or revise, as appropriate, and implement thresholds for patient injury/event indicators, including seclusion and restraint, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level and that

will be documented in the patient medical record with explanations given for changing/not changing the patient's current treatment regimen; and

5. create or revise, as appropriate, and implement policies and procedures on the close monitoring of patients assessed to be at risk, including those at risk of suicide, that clearly delineate: who is responsible for such assessments, monitoring, and follow-up; the requisite obligations to consult with other staff and/or arrange for a second opinion; and how each step in the process should be documented in the patient's medical record.

b. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents, including elopements, suicides and suicide attempts, and abuse and neglect. Such policies and procedures shall include requirements that such investigations be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;

c. Require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;

d. Monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents;

e. Create or revise, as appropriate, and implement a reliable system to identify the need for, and monitor the implementation of,

appropriate corrective and preventative actions addressing problems identified as a result of investigations;

f. Conduct a thorough review of all units to identify any potential environmental safety hazards, develop and implement a plan to remedy any identified issues, and immediately eliminate dangerous hazards in all seclusion rooms;

g. Ensure that all areas of the hospital that are occupied or utilized by patients have adequate temperature control at all times;

h. Provide sufficient professional and direct care staff to adequately supervise patients, particularly on the outdoor smoking porches, prevent elopements, and otherwise provide patients with a safe and humane environment and adequately protect them from harm;

i. Ensure that there are spare parts and equipment available for conducting routine repairs for items such as toilets, sinks, showers, kitchen daily use equipment, heating and cooling units;

j. Ensure that the elevators are fully repaired. If possible, non-ambulatory patients should be housed in first floor levels of living units. All elevators need to be inspected;

k. Replace or repair the garbage disposals in the kitchen. Priority needs to be given to repairing the dishwasher and obtaining the proper washing and rinsing temperatures;

l. Review and update the hospital fire safety and evacuation plan for all buildings and ensure that the plan is approved by the local fire authority; and

m. Create or revise, as appropriate, and implement proper procedures to remove dirty linens and clothing from the living units in a timely and safe manner.

**2. Quality Assurance**

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

a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by St. Es, 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 implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.

**B. RESTRAINT AND SECLUSION**

St. Es should 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, St. Es should:

1. Ensure that restraints and seclusion:

a. are used in a reliably documented manner;

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

c. will be terminated once the person is no longer an imminent danger to himself or others.

2. 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;

    b. the training that all staff receive in the management of the patient crisis cycle and the use of restrictive procedures; and

    c. the use of side rails on patient beds, including a plan:

        i. to reduce the use of side rails as restraints in a systematic and gradual way to ensure the residents' safety; and

        ii. to ensure that residents' individualized treatment plans address the use of side rails for those who need them, including identification of the medical symptoms that warrant the use of side rails and plans to address the underlying causes of the medical symptoms.

3. Ensure that if a physical, non-mechanical restraint is initiated, the patient is assessed within an appropriate period of time of his/her being physically restrained and an appropriately trained staff member makes a determination of the need for continued physical, mechanical, and/or chemical restraint, and/or seclusion.

4. Ensure that a physician's order for seclusion or restraint include:

    a. the specific behaviors requiring the procedure;

    b. the maximum duration of the order;

    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;

d. ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention;

e. ensure that at least every thirty (30) minutes, patients in seclusion or restraint must be re-informed of the behavioral criteria for their release from the restrictive intervention;

f. ensure that immediately following a patient being placed in seclusion or restraint, the patient's treatment team reviews the incident, and the attending physician documents the review and the reasons for or against any change in the patient's current pharmacological, behavioral, or psychosocial treatment;

g. comply with 42 C.F.R. § 483.360(f) as to assessments by a physician or licensed medical professional of any resident placed in seclusion or restraints; and

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

## C. PSYCHIATRIC AND PSYCHOLOGICAL CARE AND TREATMENT

### 1. Treatment Planning Process

St. Es should develop and implement an integrated treatment planning process consistent with generally accepted professional standards. More particularly, St. Es should:

a. Create or revise, as appropriate, and implement policies and procedures regarding the development of treatment plans consistent with generally accepted professional standards;

b. Create or revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, strengths-based, outcome-driven, emanates from an integration

of the individual disciplines' assessments of patients, that goals and interventions are consistent with clinical assessments and is otherwise consistent with a person-centered and recovery-based model that utilizes positive behavioral supports and the strengths of individuals;

c. Ensure that treating psychiatrists verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated;

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

e. Ensure that the medical director timely reviews high-risk situations such as individuals requiring repeated use of seclusion and restraints;

f. Create or revise, as appropriate, and implement programs for individuals suffering from both substance abuse and mental illness problems; a cognitive remediation program for individuals with cognitive impairments; and programs for individuals with forensic status; and

g. Create or revise, as appropriate, and implement mechanisms to ensure that all individuals adjudicated Not Guilty by Reason of Insanity ("NGRI") receive ongoing assessments by the interdisciplinary treatment team that are timely and adequate to enable the courts to review effectively and in a timely manner appropriate modifications in the individual's legal status and/or need for less restrictive care.

## 2. Assessments and Services

### a. Psychiatric Assessments and Diagnoses

St. Es should ensure that its patients receive accurate, complete, and timely psychiatric assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, St. Es should:

i. create or revise, as appropriate, and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments. Ensure that initial assessments include a plan of care that outlines specific strategies, with rationales, including adjustments of medication regimens and initiation of specific treatment interventions;

ii. ensure that psychiatric reassessments are completed within time-frames that reflect the individual's needs, including prompt evaluations of all individuals requiring restrictive interventions;

iii. develop diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses;

iv. develop a clinical formulation for 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;

v. ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, establish and perform further

assessments for a differential diagnosis, and finalize all diagnoses listed as "NOS" (not otherwise specified)" or "R/O" (rule-out);

vi. create or revise, as appropriate, psychiatric assessments of all patients, providing clinically justifiable 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;

vii. ensure that all physician trainees completing psychiatric assessments are supervised by the attending psychiatrist. In all cases, the psychiatrist must review the content of these assessments and write a note to accompany these assessments. The note must detail the review and include any additional information in areas that are not covered in the assessments;

viii. create or revise, as appropriate, and implement an admission risk assessment procedure, with special precautions noted where relevant, that includes information on the categories of risk (e.g., suicide, self-injurious behavior, violence, elopement, sexually predatory behavior, wandering, falls, etc.); whether the risk is recent and its degree and relevance to dangerousness; the reason hospital level of care is needed; and any mitigating factors and their relation to current risk;

ix. create or revise, as appropriate, and implement 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 evaluations, progress notes and transfer and discharge summaries, and require the physician peer review system to address the process and content of assessments and reassessments, identify individual and group trends and provide corrective follow-up action; and

x. create or revise, as appropriate, and implement an inter-unit transfer procedure that specifies the format and content requirements of transfer assessments, including the mission of all units in the facility.

**b. Psychological Assessments and Diagnoses**

St. Es should ensure that its patients receive accurate, complete, and timely psychological assessments, consistent with generally accepted professional standards, and that these assessments support adequate behavior and treatment programs. To this end, St. Es should ensure that:

i. Prior to developing the treatment plan, psychologists provide a psychological assessment of the patient that includes appropriate patient information, including but not limited to:

a. precipitating factors and reason for admission;

b. background information (including developmental, psychosocial, educational, substance abuse and mental health history);

c. history of psychological testing, including cognitive and personality variables (including dates, locations, examiners, scores/results, and qualifying statements as available);

d. history of any brain injury (including nature of injuries, dates, course of treatment and recovery, and impact on current functioning);

e. legal and forensic history;

f. mental status examination and observation of behavior (including results of any formal testing conducted for purposes of current evaluation);

g. assessment of risk for harm factors;

h. strengths, interests, motivation and ability to change;

i. cognitive and personality factors affecting treatment need and treatment response; and

j. a summary that contains conclusions which specifically address the purpose of the assessment with the empirical basis for the conclusions; any remaining unanswered questions; and recommendations for psychological intervention.

ii. where applicable, if behavioral intervention is indicated, further assessments be conducted in a manner consistent with generally accepted professional standards.

iii. provide adequate numbers of psychologists for every unit, psychologists with expertise in behavior management, and neuropsychologists to provide adequate assessments and behavioral treatment programs.

**c. Psychiatric Services**

St. Es should provide adequate psychiatric supports and services for the treatment of its patients, including medication management and monitoring of medication side-effects in accordance with generally accepted professional standards. More particularly, St. Es should:

i. create or revise, as appropriate, and implement policies and procedures requiring clinicians to document their analyses of the benefits and risks of chosen treatment interventions;

ii. ensure that the treatment plans at St. Es include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, and possible side effects. Reassess the diagnosis in those cases that fail to respond to repeat drug trials;

iii. ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, St. Es should:

a. ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;

b. ensure regular exchanges of data between the psychiatrist and the psychologist and use such exchanges to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies; and

c. integrate psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap.

iv. ensure that all psychotropic medications are:

a. prescribed in therapeutic amounts;

b. tailored to each patient's individual symptoms;

c. monitored for efficacy against clearly-identified target variables and time frames;

d. modified based on clinical rationales; and

e. properly documented.

v. ensure that the psychiatric progress note documentation includes:

a. the rationale for the choice and continued use of drug treatments;

b. individuals' histories and previous responses to treatments;

c. careful review and critical assessment of the use of PRN medications and the use of this information in timely and appropriate adjustment of regular drug treatment;

d. justification of polypharmacy in accordance with generally accepted professional standards; and

e. attention to the special risks associated with the use of benzodiazepines, anticholinergic agents and conventional and atypical antipsychotic medications with particular attention given to the long-term use of these medications in individuals at risk for substance abuse, cognitive impairments, or movement and metabolic disorders.

vi. institute an appropriate system for the monitoring of individuals at risk for TD that includes a standardized rating instrument used by properly trained staff in a timely manner. Ensure that the psychiatrists integrate the results of these ratings in their assessments of the risks and benefits of drug treatments.

vii. institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, St. Es should:

a. create or revise, as appropriate, and implement and continually update a complete set of medication guidelines that address the indications, contraindications, screening procedures, dose requirements and expected individual outcomes for all psychiatric medications in the formulary that reflects generally accepted professional standards;

b. based upon adequate medication guidelines, create or revise, as appropriate, and implement a Drug Utilization Evaluation procedure based on adequate data analysis that includes both random and systematic reviews, prioritizes high risk medications, and produces individual and group practitioner trends;

c. create or revise, as appropriate, and implement a procedure for the identification, reporting and monitoring of adverse drug reactions ("ADRs") that includes the definition of an ADR, likely causes, a probability scale, a severity scale, interventions and

outcomes and that establishes thresholds to identify serious reactions;

d. create or revise, as appropriate, and implement an effective Medication Variance Reporting system that captures both potential and actual variances in the prescription, transcription, procurement/ordering, dispensing/storage, administration and documentation of medications, and identifies critical breakdown points and contributing factors;

e. create or revise, as appropriate, 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, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses;

f. ensure that PRN psychotropic medications are used only as a short-term measure to relieve a patient in acute distress, not as means to escape mild, possibly healthy, discomfort or as a repeatedly deployed substitute for treatment; and

g. reduce its use of seclusion, restraints, and psychotropic PRN medications.

viii. establish monitors to ensure the appropriate use of high-risk medications, including:

a. long-term benzodiazepine and anticholinergic medications particularly for individuals with substance use problems, cognitive impairments and current or past history of TD, as indicated; and

b. the use of conventional antipsychotics, particularly for individuals with current or past history of TD.

ix. establish a system for the pharmacist to communicate drug alerts to the medical staff in a timely manner; and

x. provide adequate levels of psychiatric staffing to ensure coverage by a full-time psychiatrist for no more than 12 individuals on the acute care units and no more than 24 individuals on the long-term units.

**d. Psychological Services**

St. Es should provide psychological supports and services adequate to treat the functional and behavioral needs of its patients according to generally accepted professional standards, including adequate behavioral plans and individual and group therapy appropriate to the demonstrated needs of the individual. More particularly, St. Es should:

i. ensure that psychologists provide unit-based services that include initial assessment, treatment rounds, treatment planning, behavioral plans, and individual therapy for patients on their units/treatment teams;

ii. ensure that psychologists adequately screen patients for appropriateness of individualized behavior plans, particularly patients who are subjected to frequent restrictive measures, patients with a history of aggression and self-harm, treatment refractory patients, and patients on multiple medications;

iii. ensure that behavior plans contain a description of the maladaptive behavior, a functional analysis of the maladaptive behavior and competitive adaptive behavior that is to replace the maladaptive behavior, a documentation of how reinforcers for the patient were chosen and what input the patient had in their development, and the system for earning reinforcement;

iv. ensure that behavioral interventions are the least restrictive alternative and are based on appropriate, positive behavioral supports, not the use of aversive contingencies;

v. ensure that psychologists treating patients have a demonstrated competence, consistent with generally accepted professional standards, in the use of functional assessments and positive behavioral supports;

vi. ensure that psychosocial, rehabilitative, and behavioral interventions are monitored appropriately against rational, operationally defined, target variables and revised as appropriate in light of significant developments and the patient's progress, or the lack thereof; and

vii. ensure sufficient psychological staff to provide psychological services in accordance with accepted professional standards.

**D. NURSING AND UNIT-BASED SERVICES**

St. Es should provide nursing and unit-based services to its patients consistent with generally accepted professional standards. Such services should result in St. Es patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, St. Es should:

1. Ensure that, before they work directly with patients, all nursing and unit-based staff 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.

2. Ensure that nursing staff monitor, document, and report accurately and routinely patients' symptoms, actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.

3. Ensure that nursing staff document properly and monitor accurately the administration of medications.

4. 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 Records.

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

6. Ensure that staff responsible for medication administration regularly ask patients about side effects they may be experiencing.

7. Ensure that staff monitor, document, and report the status of symptoms and target variables in a manner enabling treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.

8. 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.

9. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, St. Es should:

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

   b. assess 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 St. Es' quality assurance review; and

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

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

**E. PHARMACY SERVICES**

St. Es patients should receive pharmacy services consistent with generally accepted professional standards. More particularly, St. Es should:

1. Create or revise, as appropriate, and implement policies and procedures that:

   a. require pharmacists to complete regular, appropriate reviews of patients' entire medication regimens, track the use of psychotropic PRN medications, and, as warranted, make recommendations to the treatment team about possible drug-to-drug interactions, side effects, medication changes, and needs for testing; and

   b. require that physicians consider pharmacists' recommendations, clearly document their responses and actions taken, and for any recommendations not followed, provide an adequate clinical justification.

**F. DOCUMENTATION OF PATIENT PROGRESS**

St. Es should ensure that patient records accurately reflect patient progress, consistent with generally accepted professional standards. More particularly, St. Es should:

1. Create or revise, as appropriate, and implement policies and procedures setting forth clear expectations regarding the content and timeliness of progress notes, transfer notes, and discharge notes; and

2. Ensure that such records include meaningful, accurate assessments of a patient's progress relating to the treatment plan and treatment goals.

**G. DISCHARGE PLANNING AND PLACEMENT IN THE MOST INTEGRATED SETTING**

Within the limitations of court-imposed confinement and public safety, the District should pursue actively the appropriate discharge of patients and ensure that they are provided services in the most integrated, appropriate setting

that is consistent with patients' needs. More particularly, St. Es should:

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 or psychiatric distress;

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

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

2. 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;

3. Provide the patient adequate assistance in transitioning to the new setting;

4. 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;

5. Ensure that the patient is an active participant in the placement process; and

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. developing 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. hiring enough staff to implement these minimum remedial measures with respect to discharge planning.

* * * * *

The collaborative approach that the parties have taken thus far has been productive. We hope to continue working with the District in this fashion to resolve our significant concerns regarding the care and services provided at St. Es.

Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. Although their 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 you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing areas requiring attention.

We are obliged by statute to advise you that, in the unexpected 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 would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. The lawyers assigned to this matter will be contacting your attorneys to discuss this matter 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/ Wan J. Kim

Wan J. Kim
Assistant Attorney General

cc: Mr. Kenneth L. Wainstein
United States Attorney
District of Columbia

The Honorable Robert J. Spagnoletti
Attorney General
District of Columbia

Ms. Ella Thomas
Interim Director
Department of Mental Health (DMH)

Ms. Joy Holland
Chief Executive Officer
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