Oregon State Hospital System

Results of the 2006 U.S. Department of Justice review of conditions and practices at the Salem and Portland campuses of the Oregon State Hospital

Overview

The U.S. Department of Justice (USDOJ) Civil Rights Division is responsible under the 1997 Civil Rights of Institutionalized Persons Act (CRIPA) for investigating conditions and practices at public psychiatric institutions. USDOJ regularly conducts reviews of such institutions throughout the United States to ensure protection of the constitutional and federal statutory rights of patients with mental illness who are being treated in public institutions.

During November 2006 USDOJ investigated conditions and care practices at the Salem and Portland campuses of the Oregon State Hospital (OSH). The inquiry included on-site interviews of administrative staff, mental health care providers and patients. Investigators also examined the physical living conditions at the two facilities and reviewed hundreds of documents including policies and procedures, incident reports, and medical and mental health records.

Following that review, USDOJ provided a report in January 2008 to the Oregon Department of Human Services (DHS) advising DHS of USDOJ's findings. The report, per CRIPA requirements, includes recommended remedial steps for OSH to take to correct any reported deficiencies.

USDOJ stated in its report that "It is apparent that many OSH staff genuinely are concerned for the well-being of the persons in their care. These staff members display admirable dedication and undertake significant efforts to provide appropriate treatment and improve the lives of OSH patients."

However, USDOJ found deficiencies in five general areas:

- Adequately protecting patients from harm,
- Providing appropriate psychiatric and psychological care and treatment,
- Use of seclusion and restraints in a manner consistent with generally accepted professional standards,
- Providing adequate nursing care, and
- Providing discharge planning to ensure placement in the most integrated settings.

The next section provides more details about these findings and OSH's actions to remedy the identified deficiencies.

Findings and responses

Inadequate protection of patients from harm

Findings

- There is widespread patient-against patient assault, unchecked self-injurious behavior, and a high rate of falls.
- The housing units contain environmental hazards, some of which pose risks of serious injury, illness and death.
- OSH's ability to address patient safety is hampered by inadequate incident management and quality assurance systems.

Actions

Thus far, OSH has taken the following actions to better protect patients from harm:

- Received approval and $458.1 million in funding from the 2007 Oregon Legislature to replace OSH with two new, state-of-the-art psychiatric hospitals. The hospitals will be located in Salem (opening in 2011) and Junction City (opening in 2013). Many of the recommendations in the USDOJ report will be addressed with the opening of these new facilities.
- Received $9.3 million from the January 2006 Legislative Emergency Board to boost hospital staffing and speed patient discharges. The money was earmarked to hire 30 new staff members, move 71 patients into community-based programs, and renovate the Portland OSH campus to create bed space for patients who had been living in the most-dilapidated building on the Salem campus.
- Implemented a Continuous Improvement Plan process that includes actions to address patient safety.
- Implemented The Joint Commission (for the accreditation of health care organizations) 2008 National Patient Safety Goals.
- Educated all staff on Professional Assault Crisis Training (ProACT).
- Created an electronic critical incident and medication error reporting system.
- Improved critical incident review and response/improvements follow-up.
- Expanded a falls reduction program hospital-wide.
- Supported mandatory pain reduction training for all licensed staff.
- Revised and implemented dangerousness risk assessments hospital-wide.
- Continued seclusion/restraint reduction efforts.
- Promoted a non-violence campaign hospital-wide.
- Trained all management leadership in Trauma-Informed Care.
- Completed fire drills and extinguisher checks as scheduled.
- Trained all staff in asbestos awareness, safe equipment operations, and use of personal protective equipment.
- Cataloged all asbestos in the facility and certified staff in asbestos abatement.
- Met all Occupational Safety and Health Administration requirements.

Lack of appropriate psychiatric and psychological care and treatment

Findings

- Psychiatric practices at both campuses lack adequate assessments and diagnoses, behavioral management services, and medication management.
- Patients do not receive comprehensive treatment planning that integrates assessment and input from mental health professionals representing a variety of disciplines.

Actions

Thus far, OSH has taken the following actions to improve mental health care and treatment:

- Entered into a two-year agreement with Oregon Health & Science University (OHSU) to add a chief psychiatrist, six additional psychiatrists/physicians and one research assistant to the Salem OSH campus to improve patient care.
- Implemented a Continuous Improvement Plan process that includes actions to address mental health care and treatment.
- Increased active, centralized treatment services at the Portland OSH facility and completed plans to implement this at the Salem OSH campus in August 2008.
- Established a consumer-run Empowerment Center.
- Implemented evidence-based practice of Relapse Prevention hospital-wide.
- Implemented evidence-based practice individual and group therapies.
- Supported Certified Alcohol and Drug Counselor (CADC) training for mental health credentialed staff.
- Provided Dual Diagnosis Anonymous (mental health and addictions) groups.
- Created Community Reintegration Program for addictions, which supports community transitions, employment and education.
- Established best-practice, self-help coping skills training, Recovery International, hospital-wide.
- Expanded vocational and educational services hospital-wide.
- Implemented a medication accuracy and interaction verification system.
- Created involuntary medication procedures to protect patients' rights.
- Enhanced physician peer review for completeness and quality of assessments and diagnosis, and evidence-based prescribing.
- Improved behavior support plans.
- Improved physician recruitment.
- Renewed all hospital and residential licenses with the State of Oregon.
- Addressed The Joint Commission findings and received continued conditional accreditation.
- Received continued certification by Centers for Medicaid and Medicare Services (CMS).

Inappropriate use of seclusion and restraints

Findings

- OSH's use of seclusion and restraints is overly permissive.
- OSH uses seclusion and restraints as an alternative to treatment and as an improvised response to patient behavior.
- OSH inadequately monitors secluded and restrained patients.

Actions

Thus far, OSH has taken the following actions to improve the use of seclusion and restraints:

- Continued the activities of the Seclusion/Restraint Committee per statute, including incorporation of community members into the committee.
- Comprehensively reviewed policies and procedures on an ongoing basis to ensure the safest practices while implementing strategies to reduce and eliminate use of seclusion and restraints (e.g., ProACT, nursing assessments and non-violence campaign).
- Trained staff in the use of least restrictive interventions and avoidance of seclusion and restraints.
- Created an emergency alert system to ensure rapid and sufficient staff response to crisis situations.
- Implemented staff and patient debriefings and support for all Seclusion/Restraint Committee events.

Inadequate nursing care

Findings

- OSH suffers from a chronic nursing shortage that results in inadequate monitoring of patients' vital signs, lack of adequate documentation and monitoring of medication administration, and failure to implement adequate infection control procedures.
- The nursing staff lacks adequate support, training and supervision.
- OSH lacks a formal mechanism with which to analyze the specific needs of each unit and determine the number and skill mix of the nursing staff required by each unit.

Actions

Thus far, OSH has taken the following actions to improve nursing care:

- Received approval from the 2007 Oregon Legislature for an additional 17 registered nurse positions for OSH, an additional 10 staff to address safety issues, two security technicians, and continuation of two pharmacy technicians and an administrative specialist.
- Implemented a Continuous Improvement Plan process that includes actions to address nursing care and staffing levels.
- Established and implemented guidelines for behavioral precautions.
- Revised and implemented a comprehensive admission nursing assessment including risk for falls, pain level and trauma history.
- Revised nursing pharmacy procedures to ensure accurate, safe medication administration.

- Improved infection control: hired a full-time nurse epidemiologist and implemented a hand hygiene campaign.
- Improved coordination with dietary services to improve nutrition wellness.
- Led efforts at pain and fall reduction hospital-wide.

Inadequate discharge planning and community reintegration

Findings

- Treatment teams typically do not consider or integrate criteria for discharge into treatment planning.
- Patients' discharge plans frequently lack discussion of the follow-up supports and services essential for successful transitions to the community.
- The discharge process allows community providers to subjectively select patients on the hospital's placement list, leaving patients with the most challenging behaviors to wait up to a year for placement into a community care setting.

Actions

Thus far, OSH has taken the following actions to improve discharge planning and patients' reintegration with the community:

- Began developing a new care and treatment program for the new psychiatric treatment facilities, which is expected to improve OSH's ability to address many of USDOJ's findings relative to discharge planning and community reintegration.
- Implemented a Continuous Improvement Plan process that includes actions to address discharge planning and community reintegration.
- Adopted an evidence-based level of care placement tool.
- Improved discharge risk assessments.
- Implemented relapse prevention groups to ensure all patients have a relapse prevention plan.
- Improved tracking of discharge-ready patients' status and efforts toward placement.
- Coordinated with state agencies and the Psychiatric Security Review Board, AMH Community Development Team, and Extended Care Management Unity to increase safe discharges.
- Created weekly review and problem-solving of "exceptional barriers" to increase discharges of patients with special needs.
- Created community transition social worker positions to facilitate successful discharges.

Timeline

- 2004: The Governor's Mental Health Task Force recommended changes at Oregon State Hospital (OSH) to strengthen Oregon's mental health system.
- January 2006: The Legislative Emergency Board authorized $9.3 million to boost hospital staffing and speed patient discharges. The money was earmarked to hire 30 new staff members, move 71 patients into community-based programs, and renovate the Portland OSH campus to create bed space for patients who had been living in the most-dilapidated building on the Salem campus.
- June 14, 2006: The U.S. Department of Justice notified Oregon Governor Ted Kulongoski that the USDOJ Civil Rights Division was conducting an investigation into conditions and treatment within Oregon State Hospital.
- August 2006: OSH retained two nationally regarded psychiatric hospital consultants to assist OSH with developing and implementing a Continuous Improvement Plan process.
- November 2006: DHS temporarily reassigned the Pendleton superintendent to Salem to deal with increased workload issues.
- November 2006: OSH entered into a two-year agreement with Oregon Health & Science University (OHSU) to add a chief psychiatrist, six additional psychiatrists/physicians and one research assistant to the Salem OSH campus to improve patient care.
- November 2006: DHS assembled a key stakeholder workgroup to develop a comprehensive plan for increasing the availability of psychiatric nurses.
- Nov. 13-16, 2006: The USDOJ conducted an on-site visit and review of OSH.
- February 21, 2007: OSH was awarded "Conditional Accreditation" by The Joint Commission (formerly the Joint Commission on the Accreditation of Health Care Organizations, or JCAHO), continuing its standing as an accredited hospital. OSH expects to receive "Full Accreditation" in 2008.
- April 2007: OSH implemented a Continuous Improvement Plan process with specific goals, actions and timelines.
- 2007: The Oregon Legislature approved $458.1 million for replacing OSH with two new, state-of-the-art psychiatric hospitals. The hospitals will be located in Salem (opening in 2011) and Junction City (opening in 2013). The state has contracted with architects and an engineering and construction firm, and is in the design phase for the first facility. Many of the recommendations in the USDOJ report will be addressed with the opening of these new facilities.
- 2007: The Oregon Legislature approved an additional 17 registered nurse positions for OSH, an additional 10 staff to address safety issues, two security technicians, and continuation of two pharmacy technicians and an administrative specialist.
- January 9, 2008: DOJ released the report of its investigation of OSH. DHS and OSH are reviewing the report in detail and will provide a formal response to the report by late February detailing plans to implement the report's recommendations.
- January 2008: The Addictions and Mental Health Division distributed management follow-up assignments for each of the recommendations contained in the report.
- 2009: DHS will request additional positions from the 2009 Oregon Legislature to improve patient care and safety. Research is under way to determine the appropriate numbers and types of positions to request.

Fast facts about OSH

- DHS operates three psychiatric treatment hospitals in Salem, Portland and Pendleton.

- The Salem hospital complex contains more than 70 buildings on 144 acres. The campus buildings comprise 1.2 million square feet, of which 970,000 square feet is usable space.

- The Portland facility is located on four floors of the six-story former Holladay Park Hospital. The 61,250-square-foot space is leased from Legacy Health System.

- The Blue Mountain Recovery Center in Pendleton is an 89,822-square-foot facility located on 7.43 acres.

- During fiscal 2006, 71,820 adults sought community mental health services in Oregon.

- Approximately 185 civilly committed patients, 438 forensically committed patients and 118 geriatric patients are cared for in the state's three psychiatric treatment hospitals.

- On any given day approximately 741 patients are hospitalized in the OSH system.

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