

BEHIND LOCKED DOORS:

SAINT ELIZABETHS HOSPITAL

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UNIVERSITY LEGAL SERVICES, INC

Since 1996, University Legal Services, Inc (ULS), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia (D.C.). Congress vested the P&As with authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. In addition, ULS provides legal advocacy to protect the civil rights of District residents with disabilities.

ULS staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education and group advocacy efforts. ULS staff addresses client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

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EXECUTIVE SUMMARY

ULS releases this third public report on the conditions and care at Saint Elizabeths Hospital (the Hospital). Many things have changed for the better following the opening of the new Hospital. Nevertheless, failure to provide individuals with basic medical care still leaves individuals subject to serious neglect, and failure to implement behavioral plans and supports still leaves consumers and staff in danger.

The following is an in-depth look at the current conditions at the Hospital as well as events that occurred in the last two years, demonstrating that the same issues that have been addressed in the past continue to occur even in the new Hospital. The report includes statistical information describing the Hospital's current number of attacks and injuries and its use of seclusion and restraint. In a hospital with just around 300 patients, in FY 2010, there were 388 physical assaults. In July and August alone, there were 88 assaults on consumers and staff. In FY 2010, there were 63 reports of abuse, neglect, or exploitation, 10 reports of sexual assault, and 342 reports of physical injury – of which 158 were the result of physical assaults. There were seven (7) suicide attempts and twelve (12) deaths. Even the Hospital acknowledges that this is a very high level of violence, stating: “The patient injury rate of the Hospital in FY10 . . . is not only significantly higher than the national public rate . . . but a critical increase from its FY09 patient injury rate . . . Patient injuries significantly increased since April 2010 and staff injuries increased since May 2010.” See *infra* at 9.

We describe two investigations concerning safety issues: one related to an attempted suicide and one concerning a unit where many violent incidents continue to occur. One man had been identified by the court, his attorney, and his community case worker as a serious suicide risk and placed in Saint Elizabeths for his own protection. Nevertheless, the individual was given access to a razor blade and horrifically injured himself. Records show that there was an inadequate number of staff on the unit, and the staff did not take appropriate precautions to protect him. See *infra* at 10-11.

A second investigation focuses on one unit that in the last few months has experienced frequent “Code 13s” – calls for emergency assistance when violent incidents take place. Staff has regularly used mechanical or chemical restraint. Large men from security and other male staff come to control the women, some of whom have been victims of past sexual and physical abuse. One such woman has been restrained on several occasions – six times in a one month period in late 2010 and has been injured by staff during at least one of the episodes. In a five week period this fall, she was chemically restrained eleven times. Staff members also appear frightened to be on the unit. One staff member had to have her hair cut short in order to protect herself from an individual who held it so tightly. See *infra* at 11-12.

In addition, we describe seven investigations related to inadequate nursing care, including three deaths. In each case, nurses failed to do adequate assessments or keep adequate records of the care provided. Six of the seven individuals had serious medical conditions that were not addressed in a professional or competent way. One woman who had an intellectual and mental disability was failed by both the Hospital and her community care workers. She had been transferred to the hospital days before her death because of her behavior. Her autopsy found that she died from a pulmonary embolism, though it was well-known that she had a history of pulmonary embolisms and that she needed to be monitored on a daily basis for this risk. When she died, however, it appears she was no

longer on medication for her pulmonary embolism. There were no records of nurses at St. Elizabeths monitoring her for symptoms of this disorder or any suggestion that St. Elizabeths was even aware of this problem. See *infra* at 17-18.

Another consumer had very serious medical concerns: bilateral adrenalectomy, hypothyroidism, and chronic renal insufficiency. Notes in her last updated care plan said: “If she fails to take her medication HRT¹ – this could result in adrenal shock and death.” Nevertheless, her last nursing assessment update occurred almost four months before her death. Her records were inaccurate and did not meet a professional standard. In fact, the general medical officer noted that the individual was taking all medications as prescribed when, in fact, the chart itself demonstrated that she was not. She had not taken her prescribed amount of life-sustaining medication the day before her death and had taken none on the day she died. Though the staff was aware that she would refuse medication, they took no steps to develop a positive behavior plan to address the reasons for her refusal, nor did they take steps to ensure that the medical doctor was aware of her refusal. Instead, she was found that evening with a temperature of 104.3. She then descended into rapid hypotension, circulatory collapse, and cardiopulmonary arrest. Only days earlier, ULS had observed a staff person taunt her about the fact that her family had not come to visit her for the holidays. See *infra* at 21-22.

Another man who is now living in the community experienced a severe reaction to the antipsychotic medication he was given, and his life was seriously threatened. Despite these severe reactions, the staff at the Hospital did not transfer him to Greater Southeast Community Hospital (GSCH), now United Medical Center, until he was unresponsive with a recorded body temperature of 94.9 degrees. His weight had gone from a high of 132 pounds to 118 pounds in two and a half months. Moreover, the Hospital staff failed to adequately assess and treat his medical conditions upon his admission to St. Elizabeths despite the fact that he was admitted with catatonia. There are few notes in his records documenting any medical assessments, with only two written during the two weeks before he was found unresponsive and admitted to GSEH. One Registered Nurse (R.N.) note states that the consumer was observed to be “drooling profusely with protruding neck muscles.” Another R.N. note a few days later states that he was drooling heavily and that the doctor was notified. Neither note contains vital signs or an adequate nursing assessment. See *infra* at 18-19.

The U.S. Department of Justice (DOJ) assessment of the Hospital -- just released in January -- found that the Hospital is not in compliance with 130 of 204 specific provisions that, in June 2007, the Hospital agreed to meet. The Hospital was to have met each of these provisions by the end of June, 2010, and during the remaining two years of the five year agreement, the Hospital was to demonstrate that its compliance could be sustained. Nevertheless, after three and a half years of effort, the Hospital has not even met forty percent of the goals established. See *infra* at 9.

Though some care has improved because of the intervention of the Department of Justice and the Hospital’s attempts to train its staff, it is clear that the Hospital continues to put some consumers’ lives at risk. A new building has not resulted in an end of poor nursing care or units where people live in fear. Whenever individuals are institutionalized and hidden behind locked doors, it is critical that they not be forgotten. Oversight must be vigilant and unencumbered.

¹ Hormone Replacement Therapy

INTRODUCTION

In 2004, during its monitoring and records requests, ULS became aware of serious problems at Saint Elizabeths Hospital. ULS issued its first report in November 2004, describing blatant violations of the individuals' rights and a disturbing lack of respect for the individuals served. After numerous failed attempts to ensure some type of independent monitoring and evaluation of the hospital practice, ULS filed a lawsuit in Federal Court asking the court to enjoin continued practices resulting in abuse and neglect.

Throughout this time, ULS reported concerns to the DOJ. Independent of ULS, the DOJ began its own investigation resulting in a report in 2006 which found serious abuse and neglect at the Hospital. Again, independent of ULS, the DOJ and the District entered into a settlement agreement in 2007. Since that time, the Federal Court has failed to act on the ULS case, even though ULS filed over 700 exhibits demonstrating constitutional and statutory violations and requested a date for trial. Judge Hogan did, however, close discovery, preventing ULS from updating its evidence through the court system.

Nevertheless, ULS has continued monitoring the Hospital and conducting individual investigations, in addition to advocating for clients individually at the Hospital. The deaths of eleven consumers in 2007 resulted in a new report, Patients in Peril 2008 - <http://www.uls-dc.org/Patients%20in%20Peril%202008%20Final.pdf> - describing the serious failures on the part of the medical and clinical staff. The following year, ULS concentrated on one unit and provided the Hospital with a detailed report describing the serious staffing problems on that unit -- RMB 3. In 2009, ULS attached the RMB 3 report to a declaration filed in *Dixon v. Fenty*, an on-going case before Judge Hogan, and described in detail the continuation of serious problems at the Hospital. Throughout this time, the Department of Justice visited the Hospital on a bi-annual basis. To the great credit of the Hospital, it has been public about its self-evaluation and the Department of Justice's report, posting evaluations on its website: <http://www.dmh.dc.gov/dmh/cwp/view,a,3,q,639789.asp>.

Now, again to ensure that the stories of the harm and seclusion are not ignored and the public is aware of what goes on behind these locked doors, ULS presents the story of the patients at St. Elizabeths. Definitely, Saint Elizabeths has improved in significant ways. Absolutely, it is still a place deeply troubled and in need of significant reform.

METHODOLOGY

Under two Federal laws, the Protection and Advocacy for Individuals with Mental Illness (PAIMI) statute, 42 U.S.C. § 10805, and the Protection and Advocacy of Individuals with Developmental Disabilities (PADD) statute, 42 U.S.C. § 15043, P&As have the authority to investigate complaints of abuse and neglect and deaths involving people with mental illness as well as those with developmental disabilities.² On a regular basis, ULS has requested records in order to investigate allegations of abuse or neglect. In addition, based on access rights provided by the two Federal laws, ULS has continued to monitor Saint Elizabeths Hospital on a regular basis.

² According to the Hospital's FY 10 Trend Analysis (Dec. 23, 2010) at 25, 32 patients (approximately ten percent) are diagnosed with an intellectual disability.

Specifically, ULS received and reviewed the following records to prepare this report: consumer records, the District's own investigations reports, the District's reports required by the DOJ, DOJ correspondence, DOJ reports, and St. Elizabeths' performance improvement records.

THE NEW HOSPITAL: A CHANGED ENVIRONMENT

Steps from the decrepit RMB (Rehabilitation Medical Building), which at one time housed all of the consumers considered to be on the "Civil Side," and which continues to house approximately twenty-four (24) individuals, is the new Saint Elizabeths Hospital – a brand new building covered in green copper and decorated with paintings and sculptures. Upon entering, there is a "Solution Center" -- replacing a sagging desk and a contract guard who could provide little to no information about consumers or the Hospital. Staff at the Solution Center can answer questions and directly contact staff to come and meet waiting visitors. The ambiance of the front entry resembles that of a modern hospital, with clean restrooms and nice reception area.

An escorted tour will reveal a large modern gym, a treatment mall with classrooms, a sterile large kitchen area, and a beautiful large auditorium. The floors are clean and no paint is peeling on the walls. This alone has changed the atmosphere of the Hospital from one which tolerated inhumane conditions to one that demands a cleaner environment and a more professional attitude.

Certainly, the most positive change at the Hospital is the decrease in its population. When ULS filed its lawsuit in 2005, there were more than 500 patients. Now the numbers huddle just below 300. There are now three patient advocates and a director in Office of Consumer Affairs. For the most part, the consumers seem to know who the advocates are and recognize that they can ask them for help. There is a new risk manager to do investigations, and he now has a staff person to assist him. When the Department of Mental Health performs its own investigations, they are generally well done, though sometimes not sufficient. Unfortunately, many of the corrective actions required by the reports are not implemented.

There is now a volunteer coordinator who has tried to open the doors of the Hospital to the public. Because of her efforts and others, there are now some tremendous volunteer programs which bring the arts and other programs to the consumers. There is not enough funding to support these efforts.

Significantly, the leaders of the Hospital are approachable and sincerely interested in improving the Hospital. There is a new medical director who is actually on the units on a regular basis, and who is competent and caring. There have been noteworthy changes to the treatment mall with the addition of professionals who seem to understand the significance of the time they have with the consumers and the opportunity to change their lives. Unlike the past -- where much time at the treatment mall seemed to be spent getting ready for the next session -- when we ask the consumers about their time at the mall, many express satisfaction. Some say they can choose the program they go to and that they enjoy the experience. They speak of improving and getting better. Unfortunately, there are a number of consumers that are not permitted to go to the treatment mall. Often, those individuals continue to sit on the unit, waiting for something to happen or sleeping in a chair.

The positive changes, notwithstanding, the new building adopted other more isolating, institutional features. The concrete brick walls form long halls that are sterile and hollow. Art work helps and certainly the holiday door decorating contest was a treat, but the individuals spend little free time outside of their own unit. Friends and family can no longer visit with the individuals by relaxing on a couch, observing the environment their loved one lives in, but instead must meet in a very jail-like setting – a room with clear glass tables and cubicles along the walls. There is no privacy, and the walls reverberate. Staff must escort consumers to this waiting/visiting room – when they have time to leave the unit. Everyone who enters must pass through a detector, and everything is screened.³

Opportunities for choice continue to be few and far between. Adding to the jail-like feel, there are no snack machines, no cafeteria, and little opportunity for the individuals to purchase any items of their own. Even their meals are served on the unit -- on Styrofoam trays. The food seems good, but the sense of claustrophobia is intense. Individuals have access to the outside if they are on the first floor (several units are on the second floor) in small patios attached to each unit but which are inaccessible to any other area. Doors are kept locked, and individuals cannot choose when they wish to go outside for a breath of fresh air – something those living in the community would find inconceivable.

STILL AN UNSAFE PLACE TO LIVE

Status from 2005 to 2009

In the original report published by ULS in November of 2004, ULS described the death of Jane Doe,⁴ who was beaten by another consumer in an unsupervised area of the unit that was overcrowded, with overworked and unfamiliar staff. Ms. Doe was then lifted after suffering a trauma to her neck and no code was called for immediate medical assistance. The ULS report also described the serious injury of Mr. Smith by another consumer who first beat him then stomped on his head. Mr. Smith later died. Two consumers who used wheelchairs died of pulmonary embolisms; physical therapy services had been discontinued though recommended for both men.

Similarly, the original DOJ report in 2006 described the serious safety concerns:

St. E's 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 and suicides. St. Es patients are subjected to undue seclusion and restraints.

5/23/06 DOJ Findings at 3.

³ ULS staff is allowed onto the units. Nevertheless, ULS' access to consumers has been significantly diminished. Whereas ULS had its own set of keys to the old Hospital, ULS personnel must now wait for permission and a staff escort. Though the guards stationed in the front seem to understand the unique role ULS plays and, thus, do not argue with ULS personnel, ULS must nonetheless spend large amounts of time waiting for overwhelmed unit nursing staff to come meet them and escort them to the units. ULS has requested the use of a pass that it could return after each visit. This request has been denied. Once on the units, ULS continues to waste time engaging with nursing staff who insist they may not come on to the unit area.

⁴ All patient names have been changed.

In January, 2007, a horrific death of a young man with an intellectual disability occurred. He was killed by a staff member when inappropriately restrained. In 2008, ULS produced a report that was based on its observations and review of records on one unit – the behavior unit. The Hospital chose to put individuals with behavioral challenges all on the same unit and used similar behavioral techniques with everyone. The ULS report described inappropriate and confrontational staff behavior, nursing documentation that lacked an understanding of consumer-centered care, lack of treatment planning, the inappropriate use of a token economy as a behavioral intervention for everyone on the unit, and serious problems with the use of seclusion and restraint, including chemical restraint and a serious injury (broken arm) during an restraint episode. See Memorandum in Opposition to Motion to Vacate December 12, 2003 Consent Order and to Dismiss Action, *Dixon v. Fenty*, Civ. No. 1:74-cv-00285 (attachment D to Exhibit C (Declaration of Celeste Valente, # 356)) (filed Nov. 8, 2009). After ULS met with the Hospital staff to discuss our concerns, change came very slowly.

The Hospital’s Compliance Office Report of September 1, 2009 (Compliance Report 9/09) described the continuation of serious problems. The Hospital’s own report explained that the staff was not trained in how to support patients when they needed positive behavioral interventions. Compliance Report 9/09 at 10. The report also found that the Hospital needed to improve “most aspects of restraint and seclusion, especially around whether alternatives used before restraint and seclusion was [sic] used.” Compliance Report 9/09 at 143. The patient injury rate was almost twice as high as the national public rate and there were very dangerous incidents, including one involving several individuals simultaneously sexually assaulting a consumer on the very unit ULS had critiqued, Compliance Report 9/09 at 187, and “several incidents of fire setting.” Id. Though the report did not list staff injury rates, ULS was aware of several very serious injuries which resulted in staff being placed on medical leave.

Continued Fear on the Units

As in the past, ULS finds that one of the primary problems with the treatment of individuals at the Hospital is a result of the culture on the units. ULS continues to observe staff treating consumers as children and showing them little respect. As stated in the just released DOJ Report 6 dated Nov. 1-5, 2010 (DOJ Report 6) attached to Letter to E. Efron, D.C. AAG, from Jonathan Smith, Chief, Special Litigation Section, U.S. Department of Justice dated January 5, 2011, (DOJ Report 6 Cover Letter dated 1/11) at 160-61: “Although some staff demonstrated and verbalized a caring attitude toward individuals, others were entirely disengaged, often milling back and forth between work areas and areas where individuals were sitting.” Perhaps the most difficult part of living on the unit is the severe lack of choice. Though there are District laws that state that individuals with mental illness have specific rights, including the right to go outside, many of these rights are still denied to some.

Significantly, the DOJ settlement agreement, D.C. law, and the U.S. Constitution require the Hospital to provide individuals “with a safe and humane environment, ensure that these individuals are protected from harm, and otherwise adhere to a commitment to not tolerate abuse or neglect of individuals . . .” Hospital’s Compliance Office Report of October 7, 2010 (Compliance Report 10/10) at 184. Nevertheless, the Hospital’s most recent 2010 self-assessment provides little discussion of these criteria: only one and one-half pages discussing training. There is no discussion of the frequent attacks, either patient on patient, or patient and staff. Nor is there a discussion or any analysis of the extent to which the Hospital ensures that the other rights provided for in the D.C. Mental Health

Act are protected. See Compliance Report 10/10 at 184 – 85. Where the Department of Justice recommended that the Hospital:

Identify a listing of specific actions to reduce violence, such as increased recreational activities, incentives to houses⁵ which reduce violence, formation of a Peacemaker’s group among individuals in care, and implement the actions as resources become available. The specific actions are suggestions only; the hospital should adopt activities that fit its needs and resources.

Compliance Report 10/10 at 195. The Hospital’s response was “This exceeds the scope of the requirement and will not be addressed.” Id. Similarly, when DOJ recommended considering a “kick-off event for the Violence Reduction Initiative that garners enthusiasm from individuals and staff,” the report states again that this “will not be addressed.” Id.

The Hospital’s report does not explain the incidents of violence or address the root causes or actions taken in response. Nevertheless, the Hospital continues to be a violent place. In its own records, the Hospital documents an average of more than one assault a day. In FY 2010, there were 388 physical assaults. FY 10 Trend Analysis (Dec. 23, 2010) at 34. In July and August, there were 88 assaults on patients and staff.⁶ Compliance Report 10/10 at 196. These are the assaults which are reported. ULS has filed grievances in which individuals claim they have been assaulted, nevertheless, their charts do not reflect incidents. Moreover, there have been six reported suicide attempts since March. But nothing in the Compliance Report 10/10 report analyses the reasons for these attempts or describes correction actions that will be taken in response. Id.

The just released DOJ assessment of the Hospital found that the Hospital is not in compliance with 130 of 204 specific provisions that, in 2007, the Hospital agreed to meet. The Hospital was to have met each of these provisions by the end of June, 2010, and during the remaining two years of the five year agreement, the Hospital was to demonstrate that its compliance could be sustained. Nevertheless, after three and a half years of effort, the Hospital has not even met forty percent of the goals established. DOJ Report 6 Cover Letter at 12. Though much progress has been made on process, much is lacking in implementation. Consumers on the units know the difference.

In FY 2010, there were 63 reports of abuse, neglect, or exploitation, 10 reports of sexual assault, and 342 reports of physical injury – of which 158 were the result of physical assaults. FY 10 Trend Analysis at 34, 37. There were seven (7) suicide attempts and twelve (12) deaths. Id. at 34. Even the Hospital acknowledges that this is a very high level of violence, stating: “The patient injury rate of the Hospital in FY10 . . . is not only significantly higher than the national public rate . . . but a critical increase from its FY09 patient injury rate . . . Patient injuries significantly increased since April 2010 and staff injuries increased since May 2010.” Id. at 38.

⁵ In the new hospital building, the units are now called “houses.”

⁶ The Report notes that the larger number may be because of better reporting, and this may be true. The new Risk Manager now has an assistant and also appears to be taking a more active role in oversight. Nevertheless, this number of assaults leaves patients and staff afraid while on the units.

The DOJ Report 6 Cover Letter dated 1/11 praises the Hospital for improving its tracking of unusual incidents, explaining that the number of assaults from March 2010 to August 2010 went from 171 in the prior six months to 215, averaging 35 a month. DOJ Report 6 Cover Letter dated 1/11 at 2. However, this disturbingly large number of assaults is very serious. The DOJ faulted the Hospital for not using the information it was now collecting to reduce the violence. Though there were 35 corrective actions that resulted from investigations, “only eight appear to have been completed or implemented.” Id. at 4. “It is unclear which actions SEH will implement, and when.” Id. at 2.

ULS requested copies of all major unusual incident reports and investigations from May forward at the beginning of November but was told that there were over 800 pages, and the cost would exceed \$200. Because of the cost, ULS has had to substantially reduce its request.⁷

Training and a change in attitude must follow to make this institution truly a place of healing. Nevertheless, the Compliance Report 10/10 found that only 72 % of the nonprofessional nursing staff had received the required training in reporting suspected abuse, neglect and exploitation. Compliance Report 10/10 at 184.

Below are the descriptions of events that relate how lives are impacted by the neglect of a system slow to transform:

Mr. Jones⁸

Mr. Jones is a man in mid-life who has struggled with depression and schizophrenia most of his life. He has been hospitalized several times for attempting to take his life. He told the staff he had attempted suicide twelve to fifteen times, and his preferred method was cutting himself. He entered St. Elizabeths in early 2009 for an evaluation related to a criminal offense. His history of suicide attempts was prominent in his record. In his recovery plan, all of the staff members were to provide support and supervision to address his suicidal ideations. Initial documents from the court stated boldly that “[d]ue to Mr. Jones’s current mental condition, **immediate hospitalization in an inpatient treatment facility setting is necessary in order to provide treatment. Furthermore, Mr. Jones is an imminent danger to self. While in the D.C. Superior Court cellblock awaiting transfer to the hospital and during transport to the hospital, he should be closely monitored for suicidal behavior.**”

Initially, the Hospital ordered one-to-one special observation. Progress notes continued to state that he was a “very high risk for suicide” and must be “watched at all times.” However, only days later, a psychiatrist discontinued the one-to-one observation. Throughout the next couple of months, Mr. Jones continued to express suicidal ideations, many of which related to his ongoing legal troubles, but the staff supervised him less and less. His community support worker noted that his suicidal ideation was “very strong.” Nevertheless, his treatment team at St. Elizabeth decided that he

⁷ ULS requested this information pursuant to the District’s Freedom of Information Act, D.C. Code § 2-532(b), which permits agencies to waive fees where the waiver is in the public interest. ULS consistently requests this waiver and is consistently denied even though ULS has no commercial interest in the information and requests it so that we can advocate for adequate services for people with mental disabilities.

⁸ All patient names have been changed for this report.

could be returned to jail. His defense counsel, however, had serious concerns about him. Only weeks later, the Superior Court ordered his return to St. Elizabeths with a note in bold: **“MR. JONES HAS SUICIDAL IDEATIONS AND PLANS TO HARM HIMSELF.”**

Mr. Jones managed to obtain a razor blade that had not been retrieved by the staff. Mr. Jones explained that he began cutting himself at 8:00 and continued until midnight when he called for help. One staff member described the scene: “Mr. Jones was sitting on his bed: both his arms were dangling at his sides and both wrists were bleeding heavily. There was a large amount of blood on the floor. He was holding a razor in his hand. . . . I also got some sheets so we could cover the floor and get to him. As we entered the room, he took the razor, looked at us and in ‘one clean swipe’ he made cuts up both arms. He then squeezed his arms to force the blood out. I can still see the look on his face . . .” He had written a note in which he said: “Today must be the day. . . . I’d rather die than go to prison. . . . Mama, you’re a beautiful lady! And I’m sorry I’ve hurt you so . . . so much. Please go on and have a life of your own now. It is what I want.”

The Hospital was not prepared for the likelihood of a suicide, even though there were multiple warnings. There were neither enough staff members present to ensure Mr. Jones’ safety, nor enough measures taken to protect him from his declared intention of committing suicide. Given all of the warnings provided and the fact that he had been returned to St. Elizabeths from the jail for the very reason that his defense counsel and the court recognized that he was a serious suicidal risk, specific measures should have been taken. Instead, monitoring by staff became less and less frequent. For the entire two-week period leading up to Mr. Jones suicide attempt, despite the fact that Mr. Jones trial was approaching, no St. Elizabeths Hospital staff member made any progress notes in Mr. Jones’ chart. At the time of the incident, there were only two staff members on the unit, though three were assigned. One staff was supposedly running late. The fact that he had access to a razor was simply irresponsible.⁹

Unit 1D

Most recently, ULS has had particular concerns about Unit 1D, called Dix House. This unit is considered the “women’s pretrial/forensic” unit. Unlike other units, consumers are more likely to be frequently moved into and out of it to and from other settings – jail or released. The constant introduction of new personalities to an unfamiliar setting makes the atmosphere unsettling.

The unit has recently experienced a substantial number of Code 13s (calls to staff on other units for assistance to deal with a dangerous situation.) According to the Analysis of Psychiatric Emergencies from May 2010 to August 2010 (Psychiatric Emergencies Analysis) prepared by the Hospital’s Quality Improvement Unit, there were 24 such codes called between May and August 2010, more than double the number on any other ward. Psychiatric Emergencies Analysis at 4.

ULS observed two of these instances as they have occurred. Consumers have acted out, attempting to harm themselves or others. In response, individuals have been handled by mechanical or chemical restraint. Large men from security and other male staff come to control the women, some of whom have been victims of sexual and physical abuse. Though it is contrary to accepted practices to restrain a woman who has been the subject of sexual assault or physical abuse, one such woman

⁹ Mr. Jones is no longer at the Hospital.

has been restrained on several occasions – six times in a one month period in late 2010. During one such episode she was injured and claims that staff abused her. In a five week period this Fall, she was chemically restrained eleven times.

When asked what would help the unit, the consumers’ most frequent response was that they needed a full time guard on the unit because they were so very afraid. Staff too appears frightened to be on the unit. One patient with HIV has bitten staff and threatens to do so again. Another staff member had to have her hair cut short in order to get away from an individual who held it so tightly.

Clearly, there are serious behavior problems on the unit. ULS met with the administration and discussed many positive approaches that have recently been implemented on the unit. ULS is hopeful that the concentrated effort will help. Vigorous supervision must accompany these worth-while approaches. Disturbingly, only weeks after the meeting, an individual reported another very serious allegation of abuse by a staff member on the unit.

The Consumer’s Voice

Consumers have a right to file grievances when they believe their rights have been violated while in the Hospital. The Hospital must respond. ULS has assisted numerous individuals in filing such grievances when the consumers appear to have been subject to abuse or neglect. These grievances describe an unsafe place. Recently, one woman, Ms. Reynolds, who uses a wheelchair, was assaulted by another consumer. She told staff and asked to be protected from the other consumer. Over the next few days the attacker continued to threaten Ms. Reynolds. Nevertheless, she believed the Hospital took little to no action to protect her. Certainly, assaults occur, and the Hospital itself documents them in its reports to DOJ, as already described. Nevertheless, the Hospital is slow to or does not acknowledge the valid fear individual have and does not always use this as an opportunity to empower the victim and help him or her when the violence does occur.

In another grievance, a consumer said that he had been hurt by a staff member. He described the experience in detail. Several other consumers similarly described the incident. The Hospital denied it. When the consumer appealed the Hospital’s response to an External Reviewer, the results were disturbing. The accused staff member only presented a written statement. He did not even come to the hearing. Nevertheless, the External Reviewer determined, because there was an inconsistency in the evidence, the staff member’s position should be accepted. In other words, the implication is that unless someone on the staff confirms in some way that a staff member assaulted a patient, there is nothing the patient can do. The consumers’ voice was not given credence.

Just last month, an individual described being assaulted by a staff member but said he would not file a grievance and did not want ULS to report it because he was afraid of what would happen to him. He whispered, “He’s here now. But, no, I don’t want to do anything.” ULS could not assure him that the grievance process was a good alternative because, in fact, our experience has been that it does not credit the statements of the consumers over the staff, even when the staff member’s credibility cannot be judged because he or she is not at the hearing.

Continued Seclusion and Restraint Abuse

Though the Hospital has paid consultants to train the Hospital staff about protections required when using seclusion and restraint, significant change is still needed. The line staff members have the most interactions and the most influence over the patients. They can have the most impact on how a patient will respond when upset or disturbed. Nevertheless, according to the Compliance Report 10/10, 28 percent of the nurse managers had not been to the required training on seclusion and restraint. Thirty-three percent of the nonprofessional nursing staff had not attended. Only 59 percent of that nonprofessional nursing staff had attended required training on non-violent crisis intervention. Compliance Report 10/10 at 168 – 170. A recent review of the Code 13s – calls for emergency assistance -- handled between May and August, 2010 found that “[n]one of the reviewed documentation indicated that staff used individuals’ comfort plans to help them manage their stress, anger, anxiety or frustration.” Hospital’s Psychiatric Emergencies Analysis at 1.

The Hospital has now determined that incidents of seclusion and restraint (though an extreme restriction of an individual’s freedom and a high potential for abuse) are not considered unusual incidents and, thus, do not need to be reported as such and, therefore, regulations applicable to reporting unusual incidents do not apply to these incidents. Compliance Report 10/10 at 179. The incidents, which usually involve staff overpowering an individual, holding him or her down to inject a needle or force him or her into the seclusion room, only need to be reported by the doctors’ orders. Reporting seclusion and restraint in a variety of ways is important for accountability. Cross-checking from multiple sources of reporting – i.e., the unusual incident report, the doctor’s orders, the progress notes, the medication administration report – ensures that all instances are actually reported. Where the conduct can be the subject of abuse and, in fact, has been at the Hospital, it is not only important, but essential that there be multiple forms of accountability.

Nevertheless, there continue to be serious systemic problems related to the use of seclusion and restraint. The Hospital recognized in its Analysis of Psychiatric Emergencies that “[i]n general, Q[uality] I[mprovement] found it difficult or impossible to discern the details of the interventions that were attempted before situations escalated into crises and staff turned to restrictive measures such as involuntary medication.” Compliance Report 10/10 at 172 (quoting from the internal report.) In fact, the Compliance Report 10/10 notes that the Hospital’s Risk Manager substantiated that one individual was restrained/secluded in July for punishment or the convenience of staff. Compliance Report 10/10 at 173. The Risk Manager also found that an individual was placed in what purportedly was the “quiet room” but in fact was placed in the seclusion room and was not permitted to leave. “[This] [i]nvestigation of abuse or neglect were [sic] conducted and substantiated.” Compliance Report 10/10 at 175.

In one instance an individual was mechanically restrained in a prone position, even though that is violation of the Hospital’s policy, Compliance Report 10/10 at 187, and very dangerous. A similar restraint may have been the cause of the death of a consumer in 2007. And though a debriefing is required following each incident of seclusion or restraint, the report found that this was done in only 50 % of the audited cases. Compliance Report 10/10 at 178. The debriefing is tremendously important in that it requires the staff to consider the antecedents to the event and devise methods to avoid a repeat episode.

Though the Hospital refuses to call injecting medication into an individual in a behavioral emergency situation “Chemical Restraint,” such action occurs regularly. The hospital reports such

conduct by listing the use of “Tranquilizers given as STAT” or “Emergency STAT Orders.” Between December 2009 and December 2010, emergency “tranquilizers” were given 276 times. November 2010 PRISM Report at Appendix 2. On average, thirty patients received more than three such “Emergency STAT Orders” a month. *Id.* at Appendix 3. The Hospital’s Psychiatric Emergencies Analysis found that an involuntary medication was given to nearly all the patients involved in a Code 13. Psychiatric Emergencies Analysis at 1. ULS does not know whether the Hospital monitors its staff to ensure that it follows the civil rights protections and procedures established by the seclusion and restraint regulations when a patient is “tranquilized.”

Another problem reported frequently to ULS is individuals being forced to take medication even though they have tried to refuse it. Consumers have a right under the District’s law to refuse medication. If the Hospital believes that medication is needed, there is a procedure that must be followed to protect the patient’s civil rights. In one case, even where a guardian had been appointed, the Hospital unilaterally decided to forcibly medicate an individual with psychotropic medication without consulting with or obtaining the consent of the individual’s guardian. Even when the Hospital has chosen to initiate the established process for obtaining approval to involuntarily medicate a patient, individuals report that the Hospital has failed to follow the prescribed procedures; thereby, violating the individual’s civil rights.

ULS has advocated in several grievances for consumers who believe their rights have been violated. For example, in one grievance, the consumer states that ULS explained that she had a right to have a consumer advocate at the Involuntary Medication Review Panel. The consumer advocate could not attend at the hour the panel was set but could come later in the day. The individual asked that the panel meet later in the day, but the panel was held without either the consumer or the consumer advocate being present. The panel determined she could be involuntarily medicated. The next day, she was told to take the medication or staff would give it to her by injection. When she refused, she was held down by male staff, and the medication was injected. Now she accepts the injections because she fears the restraint more than the medication.

In another case, an individual states he was given powerful psychotropic medications against his will. The Hospital claims the patient was a risk to himself or others. Nevertheless, the Hospital’s records did not document that the Hospital reasonably attempted to use less restrictive alternatives, and in certain instances failed to show that alternatives to involuntary medication were even seriously considered, as is required by District of Columbia law. There was no documentation of assessments that are required after a patient is involuntarily medicated to ensure the individual is not experiencing problems with the medication. Nor was there a physician’s order for the involuntary medication. Following an external review, the external reviewer acknowledged that the records did not contain the appropriate documentation; nevertheless, she denied the consumers request for additional staff training because, though the Hospital’s policies had not been followed, there was no harm done. The reviewer found that staff simply did not have time to document as required by policy. The external reviewer did not express any concern about the fact that such a violation of standard medical practice could be the result of insufficient staff, or that insufficient staff may have been part of the reason the emergency occurred in the first place. Again to the great credit of the Department of Mental Health, the Director, Steve Baron has just rejected that decision and ordered the Hospital to provide evidence that staff are trained in the appropriate provision of involuntary medication.

CONTINUED NEGLIGENT MEDICAL CARE

In its 2004 report, Patients in Peril, ULS described a death related to a blood clot. After further investigations, ULS found serious problems with nursing care at the Hospital. Similarly, an expert hired by the Department of Justice outlined grave incidents of neglect. These descriptions and the deaths of 11 patients were outlined in ULS' report released in 2008, <http://www.uls-dc.org/Patients%20in%20Peril%202008%20Final.pdf>.

Since that report, there has not been sufficient improvement in the direct medical care of the individuals at Saint Elizabeths. ULS continues to see troublesome cases of indifference and neglect. Though some documentation may have improved, often the response is inadequate or inconsistent.

As was the case with previous reports, the DOJ's most recent report found that R.N.s' "assessments were incomplete e.g. did not consistently contain basic vital signs, did not contain pain assessment or a description of the pain, did not contain abdominal palpation and auscultation when symptoms required those actions." DOJ Report 6 at 163. The report also notes that, "Documentation of medically necessary routine and non-routine . . . information was inconsistently present . . ." *Id.* at 162. R.N. assessments involving a transfer to and from the emergency department were "incomplete" and did not contain adequate physical assessments. *Id.* at 163. The DOJ Report 6 Cover Letter dated 1/11 at 6 states: "Several observations of medication administration during the compliance tour indicated that SEH practices depart from generally accepted standards and have the potential to jeopardize the health and safety of individuals in care."

Staff working on the units continues to complain about short staffing, insisting that there are not enough staff especially during off peak hours, such as weekends, evenings, and nights. They are right to be concerned. "The nursing process is a deliberate, problem solving approach to meeting the health care and nursing needs of patients." *Manual of Nursing Practice 5* (Lippincott, Williams & Wilkins ed., 8th ed., 2006). Basic nursing care includes assessment, diagnosis, planning, implementation and evaluation of care. Not only are these steps crucial to ensure an individual's safety and well-being, the District of Columbia's registered nurse licensing regulations require them.¹⁰

¹⁰ The practice of registered nursing means the performance of acts requiring substantial, specialized knowledge, judgment, and skill based upon the principles of the biological, physical, behavioral, and social sciences in the following:

- (a) The observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms of health, disease, and injury, including the performance of examinations and testing and their evaluation for the purpose of identifying the needs of the client and family;
- (b) The development of a comprehensive nursing plan that establishes nursing diagnoses, sets goals to meet identified health care needs, and prescribes and implements nursing interventions of a therapeutic, preventive, and restorative nature in response to an assessment of the client's requirements;
- (c) The performance of services, counseling, advocating, and education for the safety, comfort, personal hygiene, and the protection of clients, the prevention of disease and injury, and the promotion of health in individuals, families, and communities, which may include psychotherapeutic intervention, referral, and consultation;
- (d) The administration of medications and the treatment as prescribed by a legally authorized health care professional licensed in the District of Columbia;
- (e) The administration of nursing services including:
 - (1) Delegating and assigning nursing interventions to implement the plan of care;
 - (2) Managing, supervising and evaluating the practice of nursing;

The Hospital's inability to ensure basic standards of nursing practice continues to result in untimely and tragic deaths and serious patient injury or deterioration. In 2010 alone, there were 12 deaths.¹¹ Following are summaries of some of the death and serious neglect investigations that ULS has handled in the time since the 2008 report. Names have been changed and facts de-identified.

Ms. Hines

Ms. Hines was in her early forties when she was admitted to Saint Elizabeths. In a little over six months, she was dead. She entered the Hospital with serious medical problems, including a diagnosis of HIV, anemia, hypotension, and asthma. Nevertheless, nursing care was scant and inadequately documented. She was almost never assessed by a medical doctor, and there is almost no evidence to indicate any quality physical assessment. Even when concern was noted – low blood sugar level, extremely low blood pressure – follow-up assessments were rare. At times, orders were ignored. For example, several months before her death, she had a blood pressure of 77/48. No follow-up blood pressure was taken. The doctor ordered her medications held, yet she was chemically restrained only minutes after the low blood pressure reading -- given injections of Haldol and Benadryl in response to an altercation.

During the month of February, 2008, there were only two nursing progress notes; neither included any kind of an assessment of her physical health. In early March, she was involuntarily medicated for talking too loud and bothering other consumers. She was given Ativan, which can lower blood pressure. The Phoenix clinic called in March to report that her “blood work reports were gravely abnormal.” Nevertheless, no appropriate assessments occurred. In April, a blood pressure

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- (3) Developing organization-wide client care programs, policies, and procedures that identify the process to be utilized by nursing personnel to assess, identify, evaluate, and meet the needs of clients or population served;
 - (4) Developing and implementing an organizational plan for providing nursing services;
 - (5) Implementing an ongoing program to assess, measure, evaluate, and improve the quality of nursing care being offered or provided; and
 - (6) Providing an environment for the maintenance of safe and effective nursing care.
 - (f) Evaluating responses and outcomes to interventions and the effectiveness of the plan of care;
 - (g) Promoting a safe and therapeutic environment;
 - (h) The education and training of person(s) in the direct and indirect nursing care of the client;
 - (i) Communicating and collaborating with other health care team members and professionals in the development of the plan of care, management of the client's health care, and the implementation of the total health care regimen;
 - (j) Teaching the theory and practice of nursing;
 - (k) Acquiring and applying critical new knowledge and technologies to the practice setting; and
 - (l) The pursuit of the nurse research to advance and enhance the practice of nursing.

D.C. Mun. Regs. tit. 17, § 5414.

¹¹ ULS is not informed of deaths by the Hospital and can usually only learn of them if other patients tell us. Upon learning of two deaths this summer, we requested the names of the individuals and contact information of the families. The D.C. government refused to provide it even though ULS has a Federal right to the information if there is a probable cause that there has been abuse or neglect. The fact that 1) the deaths in the 2008 ULS report involved Hospital neglect, 2) the DOJ expert continues to find substantial problems with nursing care, as well as 3) the neglect involved in the more recent deaths described in this report each provide ULS with “probable cause” to believe any death at the hospital involves neglect; therefore, ULS has the right to review the death records.

reading was 70/58, yet no pulse was recorded, and there was no physical assessment or follow-up blood pressure reading. There were only three nursing notes in the entire month.

The day before her death in May, 2008, she was transferred to a new unit at the Hospital. The transfer notes do not mention physical or medical problems, and there is no indication that a physical assessment was done on the new unit. On the morning of her death, she was seen going to the restroom very early. An hour later she was found unresponsive in bed. The autopsy found the cause of death: “sudden cardiac arrest associated with schizoaffective disorder and chronic hypotension.” This “hypotension” -- or low blood pressure -- had been ignored as described above.

These records establish a staff that did not follow generally accepted medical procedures to assess Ms. Hines given her serious medical issues or when she showed signs of distress. The failure to respond to take additional steps in response to the Phoenix clinic report is unexplained. The poor care may or may not have been the cause of Ms. Hines’ death; nevertheless, such care is far below any professional standard.

Ms. Thomas

In mid 2008, a woman in her thirties with an intellectual disability who was recovering from a serious Methicillin-Resistant Staphylococcus Aureus (MRSA) infection at a nursing home was involved in an altercation and sent to Saint Elizabeths Hospital. Frightened and disoriented, Ms. Thomas refused to permit the doctors to evaluate her, though she had a serious medical condition that required medical oversight and monitoring. There is no evidence that appropriate methods were used to calm her or approach her. Instead she was given psychotropic medications. Within three days, she died.

Her autopsy found that she died from a pulmonary embolism. It was known by her community care providers that Ms. Thomas had a history of pulmonary embolisms, and that she needed to be monitored on a daily basis for this risk. When she died, however, it appears she was no longer on medication for her pulmonary embolism. There were not any records of nurses at St. Elizabeths monitoring her for symptoms of this disorder or any suggestion that St. Elizabeths was even aware of this problem

As an individual with an intellectual disability who is abruptly sent to a psychiatric hospital against his or her will, it is understandable that she would have difficulty complying with a physical examination. It would be reasonable for the Hospital staff to make an extra effort to attempt to see her when she was calm. She received services from the Department on Disability Services (DDS) and its providers. It might have also helped if someone who was familiar with her, such as a DDS service coordinator, staff from her residential provider, or her family had been contacted and then been able to share strategies that had worked in the past to help her feel comfortable so that she would comply with a physical examination. However, there are no notes to suggest that these alternative approaches were considered or attempted.

The day that Ms. Thomas died, she had numerous complaints that were not addressed. The records note that she was complaining, but little additional information is available. Below is a summary of her complaints:

9:00 a.m. Patient continues to inform staff she can't walk and she feels sick.
11:00 a.m. Patient has been sitting in dayroom yelling and asking others to help her go to her room or to the bathroom.
1:00 p.m. Making numerous somatic complaints, getting peers to wait on her trying to get feeding.

The progress notes do not elaborate on what the complaints were, and there is no evidence of a nursing assessment in response to the complaints. Notably, the 9:00 a.m. note -- stating that Ms. Thomas complained she could not walk -- does not appear to have been followed up by a nursing assessment.

Ms. Thomas' health care management plan states that she should be monitored daily for pain and fatigue, two symptoms she appeared to be exhibiting the day she died. If one of the "numerous" somatic complaints was that her leg hurt, then the nurse should have assessed her leg. Nonetheless, the nurses' basic responsibilities included assessing Ms. Thomas for her known medical conditions and assessing her for any complaints of pain. If an assessment had been done, the nurse may have found symptoms of an embolism. Instead, it appears no one evaluated these symptoms on the day she died.

Moreover, on the day she died, she had a one-to-one assigned to monitor her. During Ms. Thomas' last two hours, two different R.N.s split the one-to-one assignment. Between 1:00 p.m. to 2:00 p.m., one nurse acted as Ms. Thomas' one-to-one, and between 2:00 p.m. and 3:00 p.m., another R.N. was supposed to cover one-to-one duty. However, the first R.N. did not stay with Ms. Thomas during that entire hour. Instead, at approximately 1:20 or 1:25, she stepped approximately 15-20 feet away, and went behind the nursing counter. The R.N. explained that they were short staffed and she was forced to attend to other duties. Ms. Thomas was left alone in a medication teaching group that another nurse was leading. Although another nurse was in close proximity to Ms. Thomas (approximately 3 to 5 feet) during the teaching group, the group ended at 1:45, and that nurse left to attend to other duties. Based on DMH's timeline of events, Ms. Thomas was completely alone between 1:45 p.m. and 2:03 p.m., and furthermore, no one saw her move or say anything after 1:00 p.m. She could have become unresponsive at any time during this period, but no one noticed.

Ms. Thomas spent the last few days of her life in an unfamiliar environment, complaining of feeling weak and sick, possibly in pain, with no one responding, receiving substandard nursing care. Sadly, she was dead for perhaps more than an hour -- in a circle of people, supposedly participating in a group session, with a one-on-one who was purportedly being paid to do nothing but monitor her care. When they did finally exam her, her body was cold.

Mr. Forest

Mr. Forest is a tall, young man who was admitted to the Hospital in 2008. While at the Hospital, Mr. Forest's life was seriously threatened. Mr. Forest's medical records show that he

experienced symptoms of a severe reaction to medication and lost fourteen (14) pounds. Despite these severe reactions, the staff at the Hospital did not transfer Mr. Forest to Greater Southeast Community Hospital (GSCH), now United Medical Center, until he was unresponsive with a recorded body temperature of 94.9 degrees. His weight had gone from a high of 132 pounds to 118 pounds in two and a half months.

Hospital staff failed to adequately assess and treat Mr. Forest's medical conditions upon his admission to St. Elizabeths. The records do not contain any progress notes from the time of Mr. Forest's admission until more than a month after his admission. Despite the fact that Mr. Forest was admitted with catatonia, the records do not contain any documentation indicating whether he was evaluated or followed by a medical doctor prior to the GSCH admission, except when he was examined by a medical doctor a week before being sent to GSCH, for a skin breakdown on his heel. This is especially disturbing since catatonia can be caused by a number of serious, potentially life-threatening medical conditions, and medical causes should have been ruled out.

In addition, the nursing staff provided woefully inadequate care prior to Mr. Forest's hospitalization at GSCH, placing Mr. Forest's life and well-being at risk. The records contain progress notes written by R.N.s on only three dates in January, 2008. Incredibly, no R.N. progress notes were written from that date for more than two months, and then only two were written during the next two weeks when Mr. Forest was found unresponsive and admitted to GSEH. An R.N. note in March, 2008, states that Mr. Forest was observed to be "drooling profusely with protruding neck muscles." Another R.N. note a few days later states that Mr. Forest was drooling heavily and that the doctor was notified. Neither note contains vital signs or an adequate nursing assessment.

Despite Mr. Forest's worsening condition, the records contain no evidence of adequate nursing assessments, monitoring or follow-up, even when Mr. Forest was clearly showing an increase in symptoms. The nursing assessments were inadequate even after the neurology consultation indicated that Mr. Forest was having a severe, potentially life-threatening reaction to the psychotropic medications.

Mr. Moore

Mr. Moore was admitted to St. Elizabeths in 2009. His admitting diagnoses included c-difficile diarrhea, renal insufficiency, and healed fractures of hips, right leg and right ankle. His highly contagious infection warranted extreme care with bodily matter. Nevertheless, a review of the records revealed that the nursing staff provided substandard care and treatment to Mr. Moore in the time he was at the Hospital, and that the nurses were not employing basic nursing functions. This is particularly troubling given Mr. Moore's fragile medical state on admission. The progress notes do not contain evidence that the staff adequately monitored his condition, noted his condition was significantly deteriorating, or provided an adequate response. This lack of adequate medical care placed Mr. Moore and the other individuals at considerable risk.

Despite Mr. Moore's serious medical condition on admission, the admitting R.N. progress note was very brief and did not contain an adequate nursing assessment. The note made no mention of Mr. Moore's physical condition or multiple medical diagnoses.

A 17 page form which is to be completed within eight hours of admission and which could provide a comprehensive picture of a patient if completed properly was sparsely completed; many of the categories were not filled out and most of the boxes were not checked. Pages 9 through 17 of the form, which should include a comprehensive physical assessment, are completely blank. The signature page contains no signatures. Given Mr. Moore's medical condition on admission, such failures are inexcusable.

Moreover, the progress notes indicate that the nursing staff did not adequately monitor and assess Mr. Moore's diarrhea. An R.N. note stated, "Mr. Moore had stool all over the place" Another R.N. note dated a few days later stated, "Mr. Moore was received this morning in his room full of stool." These very brief notes do not indicate that the nurses conducted adequate nursing assessments regarding the diarrhea, which would include amount, odor and consistency of stool, an abdominal assessment, and vital signs. Furthermore, the notes do not indicate whether the nursing staff notified the doctor or whether Mr. Moore received medication as ordered.

Further, the records indicate that staff did not adequately maintain contact isolation precautions, placing the other consumers and staff at risk of contracting what can be a serious c-difficile infection. The records contain no indication that the nursing staff implemented isolation precautions when Mr. Moore was admitted to the unit. Instead, the records indicate that Mr. Moore wandered freely around the unit, ate meals with the other residents and used the bathroom that the other patients used, all of which placed the other consumers and staff at risk of contracting the infection. A nursing assistant note states "Mr. Moore has been walking around the ward going to the bathroom." Another note states that Mr. Moore "was incontinent of fecal matter and needs to keep a pampers on all the time." Another progress states that stool was "smeared on consumer and bed linens." Disturbingly, even when the R.N. notes mention contact isolation precautions, the notes are brief and in most instances do not specify the contact isolation steps that staff employed.

Finally, despite Mr. Moore's diagnosis of severe malnutrition, the medical and nursing staff did not adequately address this condition. The records do not contain evidence that the physicians at the Hospital ordered nutritional supplements nor do the records indicate that the nursing staff monitored or consistently encouraged Mr. Moore's food or fluid intake. In fact, a medical doctor note states that "patient is not eating" (emphasis in original). Under the assessment portion of the note, the physician states that Mr. Moore has malnutrition and that staff should try liquid blended high protein food. Although the physician ordered this diet, the records do not indicate that staff provided this diet to him. In addition, the records do not contain a nutrition consultation, which would be clearly indicated for a diagnosis of malnutrition. In fact, the problem of malnutrition is not addressed anywhere in Mr. Moore's individual recovery plan.

Just two weeks and two days after admission, his condition warranted readmission to Washington Hospital Center,¹² at which time his serious diagnoses included cachexia (weight loss,

¹² As the Department of Justice noted in its third Report (DOJ Report 3), which summarized its findings from its visit to the Hospital between February 11 and 15, 2009, Hospital staff failed to address medical conditions that, in turn, resulted in

muscle wasting), dehydration, hypothyroidism, pulmonary infiltrates (pneumonia), hypotension (low blood pressure), and encephalopathy.

Ms. Hand

Ms. Hand was a middle-aged woman at the beginning of 2010 who had serious medical concerns, including Cushings disease, a form of diabetes that is not insulin responsive, bilateral adrenalectomy, hypothyroidism, and chronic renal insufficiency. She had been admitted to the Hospital several years before, but she had a desire to return to the community and already had been to three years of college to prepare her for work. She was usually happy, though she desperately wanted to leave the Hospital and spend time with her family.

She was taking three psychotropic medications, including one antipsychotic. According to a pharmacological plan to address adverse side effects from the medication, she was to have daily blood pressure checks, and her blood and serum lipids were to be monitored. Notes in her last updated care plan said: “If she fails to take her medication HRT¹³ – this could result in adrenal shock and death.”

Nevertheless, the nursing care provided to Ms. Hand, a woman who obviously required intensive observation and attention, was abysmal. Incredibly, the last nursing assessment update occurred almost four months before her death. Her records were inaccurate and did not meet a professional standard of care. In fact, the general medical officer noted that the patient was taking all medications as prescribed when, in fact, the chart itself demonstrated that she was not. Moreover, the medical officer’s monthly written note transcribed incorrect dosages of medications.

Ms. Hand’s health was deteriorating in early 2010. ULS noted the change with concern and actually spoke to a resident psychiatrist on the unit days before her death, asking that the doctor check on her because she looked so ill. Only days earlier, ULS had observed a staff person taunt her about the fact that her family had not come to visit her for the holidays.

In fact, she had not taken her prescribed amount of life-sustaining medication the day before her death and had taken none on the day she died. Though the staff was aware that she would refuse medication, they took no steps to develop a positive behavior plan to address the reasons for her refusal, nor did they take steps to ensure that the medical doctor was aware of her refusal. Instead, she was ignored, left in her room the whole day and found that evening with a temperature of 104.3. She then descended into rapid hypotension, circulatory collapse, and cardiopulmonary arrest.

The medical examiners’ office did not consider her a priority case and refused to execute a death certificate. United Medical Center also refused, claiming she was dead before she arrived. Though too late for Ms. Hand, the District did do a thorough investigation and took corrective action in response.

patients requiring hospitalizations: “Of particular concern is the consistent lack of attention to medical problems that present on admission or that emerge during the course of hospitalization. In some instances, medical problems on admission were not addressed and the individual subsequently required ER evaluations and/or was hospitalized for conditions that related to problems that were noted to be presented on admission but not addressed.” DOJ Report 3 at 140.

¹³ Hormone Replacement Therapy

Ms. Barton

During the summer 2010, Ms. Barton called her guardian, Mr. Guardian, in distress and informed him that she was experiencing significant chest pain. On the phone, Ms. Barton was sobbing and stating that she was having chest pain and wanted to go to the hospital. Mr. Guardian called the staff and informed them that Ms. Barton was experiencing chest pain and requested that they provide immediate medical attention. He also called the nursing supervisor to ensure that staff addressed Ms. Barton's serious complaints of chest pain.

However, progress notes for that day do not reference her complaints of chest pain, nor do they reference the telephone call from the guardian. A medical progress note that evening indicates that the medical doctor responded to a "Code 13" to address Ms. Barton's "agitated and aggressive behavior." The note states that Ms. Barton was "demanding to be transferred to Providence Hospital," although the note does not indicate the reason she wanted to be transferred. Inexplicably, neither the doctor's notes nor the nurses' notes address Ms. Barton's complaints of chest pain or Mr. Guardian's phone call informing staff of his concerns. Disturbingly, the record contains no evidence that Ms. Barton was medically assessed for her serious complaints of chest pain. Though she appears to have suffered no serious physical side-effects, the Hospital's response was not appropriate or professional.

Mr. White

Mr. White became a patient at St. Elizabeths in mid 2009. His medical condition has deteriorated significantly since then. He is extremely difficult to understand because of dystonia, and he has no assistive technology available to him to assist with communication. He has experienced numerous instances of neglect which may or may not have contributed to his deteriorating condition. The records indicate that, though Mr. White has multiple serious medical conditions, staff has not providing adequate assessments, monitoring, or treatment. A late 2010 neurology consultation Mr. White's medical diagnoses includes a history of a subdural hematoma (bleeding in the brain from trauma), cognitive deterioration, and severe tardive dyskinesia. However, the records made available for review do not contain evidence of adequate nursing assessment, planning, and monitoring of his significant medical conditions, nor do they indicate that staff provides adequate treatment when a change in clinical condition occurs.

The records reviewed did not contain a comprehensive nursing assessment. A nursing update at the end of November 2010 does not adequately address Mr. White's serious medical issues and the nursing responsibilities related to them. Under the category of "physical health" the update lists several abnormal lab results and states that Mr. White is on choking precautions and is taking a medication for gastric reflux. However, the update does not list his other serious medical conditions and several sections are entirely blank. Similarly, the "physical health" section of the most recent treatment plan in December, 2010, lists Mr. White's risk of falls and choking, but does not address his cognitive deterioration, tardive dyskinesia, and history of head trauma, which require monitoring and intervention.

Moreover, records indicate that the Hospital staff are not adequately assessing and monitoring Mr. White when he experiences a serious change in clinical condition. For example, when Mr. White reportedly fell in front of the Hospital building, a progress note indicates his temperature was elevated

to 102.3 degrees, his pulse was elevated and that he was “confused.” The same note states that the doctor was notified and that his temperature “came down to 100.1” but that his pulse remained elevated at 125. However, the next R.N. progress note in the record is not until the following day, and it does not discuss his elevated temperature, elevated pulse and confused state. Again, the nurses failed to adequately assess and monitor Mr. White’s significant change in clinical condition.

Another example of inadequate nursing assessment and monitoring occurred in late September, 2010, when Mr. White was found on the floor of his room with a deep laceration that was “up to the bone.” Despite this serious injury, the record does not contain evidence that medical or nursing staff adequately assessed Mr. White for signs and symptoms of a head injury. The doctor’s record states that Mr. White was “alert” and “follows commands;” however, the note does not contain any further evidence of an adequate evaluation, despite the severity of the laceration. In fact, the records indicate that a resident psychiatrist ordered that he be chemically restrained with an injection of additional sedating psychotropic medication in the early morning hours after the fall for “aggressive” and “loud” behavior. This was done even though a sedating medication may have been contraindicated as it could have masked the symptoms of a head injury -- especially since the records do not indicate that the nursing staff adequately monitored his condition overnight. Nothing in the record identifies or addresses the potential for complications. Moreover, there is nothing in the record that indicates that the treatment team met to address the reasons for the use of a chemical restraint and propose less restrictive approaches that might be used in the future to address his behavior.

Despite his serious fall and head injury, Mr. White was not sent to the emergency room for a proper medical evaluation until the morning after the fall. The doctor noted that morning that he “appeared drowsy” and that he was “very slow eating tremors cant [sic] hold spoon.”

The record contains one R.N. progress note almost four hours after the fall, which states that Mr. White fell and that he sustained a laceration. Except for listing vital signs, the note does not contain a nursing assessment. For example, the note does not describe Mr. White’s mental status, or pupil size and reaction. The record does not contain any other R.N. progress notes regarding the fall until he was sent to the emergency room.

Moreover, the records do not contain evidence that the nurses adequately assessed Mr. White after he returned from the emergency room. For example, nurses’ notes state that Mr. White was “confused,” “disoriented” and “restless,” yet the notes do not indicate that the nurse performed a more detailed assessment, notified the medical doctor of his behavior, or took any other action except to monitor Mr. White.

Yet, he was so agitated that he was again chemically restrained. Disturbingly, a doctor’s note on the day of Mr. White’s return states that staff “gave Lorazepam 2 mg IM, instead of Haloperidol. It appeared to me that there was a miscommunication because of the chaos on the unit. Patient will be monitored for excessive drowsiness.” The nurses’ notes do not address this error, nor is there indication in the notes that the nurses monitored Mr. White for excessive drowsiness, despite his recent head injury. Again, there is not anything in the record that indicates that the treatment team met to address the reasons for the use of a chemical restraint and propose less restrictive approaches that might be used in the future to address his behavior.

A GMO progress note indicates that Mr. White sustained a fracture from the fall. However, this injury is not referenced again in the records and it is not clear what, if any, treatment has been indicated or rendered regarding the fracture.

RECOMMENDATION

As in prior reports, ULS continues to be deeply concerned with the Hospital's lack of progress towards the reforms demanded by the DOJ settlement agreement. This slow reform jeopardizes the safety and well-being of the individuals that reside there. The incidents of patient assault and injury are too high. Staff continues to use chemical restraint to control maladaptive behavior. This approach is far from person-centered and hinders the establishment of trust needed for recovery.

Moreover, as ULS already explained in Patients in Peril 2008, medical records and the District's own investigations of the consumers' deaths, illness, and the suicide attempt continue to reveal a number of distressing patterns: significant gaps in both nursing and physician leadership; deficiencies in the delivery of medical care; and nurses' failure to perform basic and fundamental nursing functions, such as assessments, care planning, and implementation of nursing plans. As the primary caretakers of St. Elizabeths patients, R.N.s have the responsibility to perform their professional duties adequately. Even when individuals experience significant deteriorations in their medical conditions, the nursing staff frequently does not perform adequate assessments and follow-up, placing the patients at risk of further decline and worsening symptoms, some of which are not recognized or treated until it is too late.

Given the continued failure to provide adequate care, even following the explicit description of problems laid out in ULS' report Patients in Peril 2008, ULS again urges the District to take a number of immediate steps to prevent more needless suffering, or worse, more deaths.

- First, both the Hospital and the Department of Mental Health should conduct death investigations of every death at the Hospital to identify problems with the quality of care, and take any and all corrective action, including personnel action, where indicated. The DMH oversight authority should review corrective actions monthly until completed.
- Second, ULS should be informed of each death and provided with family contact information. Additionally, ULS should receive, free of charge, all major unusual incident reports, enabling it to investigate those that may be the result of abuse or neglect.
- Third, given the Hospital's serious failures, the District should retain an independent expert to perform a thorough investigation of the current provision of medical services to all consumers with any secondary medical concerns. The results of such an investigation should be made public so that the Hospital and the District can be held accountable. Any recommended changes should be monitored and progress should be made public on a monthly basis.

- Fourth, the Hospital must continually train all nursing staff on basic nursing practice. Staff should be continually assessed for competence. Statistics noting completion of trainings should be posted on the internet.
- Fifth, the Hospital must develop the necessary protocols to monitor medication side effects, and specific check lists for individual with serious complicated medical needs. Then there must be sufficient monitoring to ensure the protocols are followed, and monthly reports on accuracy made public.
- Sixth, the Hospital must hire sufficient nursing and medical staff as required by the DOJ settlement -- to ensure that it can adequately monitor every individual's condition, and respond to clinical changes, whether medical or psychiatric in nature.
- Seventh, the Hospital must ensure that the nursing and medical administration is capable of and actually provides the leadership necessary to make these and other critical changes necessary to ensure consumer safety at St. Elizabeths Hospital.

Though some care has improved because of the intervention of the Department of Justice and the Hospital's attempts to train its staff, it is clear that the Hospital continues to put lives at risk. A new building has not resulted in an end to poor nursing care or violence on units. Whenever individuals are institutionalized and hidden behind locked doors, the public must continually take steps to ensure that they are not forgotten and that their rights are protected.