

# Patients in Peril

A Report on the Dangerous Conditions and Substandard  
Care at St. Elizabeths Hospital

November 4, 2004

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The information contained in this report derives from a range of sources: a review of patients' medical records at St. Elizabeths Hospital, the July 14, 2004 Centers for Medicaid and Medicare Services' audit findings of deficiencies, information provided by staff, patients and their families at St. Elizabeths Hospital and University Legal Services' first-hand observations and monitoring activities.

## **THE CRISIS**

The patients and staff at St. Elizabeths Hospital, the District of Columbia's only publicly operated psychiatric hospital, face serious risks to their health and safety everyday. Many conditions contribute to these dangers, including but not limited to:

- overcrowded wards
- inadequate clinical staff
- insufficient medical resources
- overworked and demoralized staff
- deficient quality assurance/improvement efforts
- inefficient mechanisms for discharging consumers to community-based alternatives
- substandard physical conditions

These conditions have resulted in serious injury to patients and staff, as well as several recent patient deaths, which can be attributed to the hospital's inadequate medical resources, insufficient staffing and a deficient quality assurance program. For example, in the spring of 2004, an elderly patient was attacked by a fellow patient and killed. Also last spring, a patient who had been at St. Elizabeths for only three days was repeatedly stomped on his head and face by another patient, resulting in severe injury and a coma. In late 2003, another patient died of a blood clot to the lung that might have been prevented had he received the physical therapy that his doctors had repeatedly ordered. And in the spring of 2003, a forensic patient gouged out his eyes with his hands while under a physician's order to be restrained in four-point restraints and assigned one-to-one staff supervision. Staff are not immune from harm either. This past spring, a psychiatrist who had only recently joined the staff at St. Elizabeths resigned after being physically assaulted and injured by a patient.

While the hospital's widespread deficiencies have created a more unstable and unsafe environment for patients and staff, they have also had a tremendous impact on the quality of care and treatment for the vulnerable patients who are at St. Elizabeths.

In June 2004, the Centers for Medicare and Medicaid Services (CMS), the agency of the federal government responsible for operating the Medicare program, spent several days there conducting an unannounced recertification and complaint survey, prompted by two violent incidents that occurred last spring. While at St. Elizabeths Hospital, the CMS surveyors investigated the hospital's compliance with minimally acceptable standards of care and treatment. On July 14, 2004, CMS issued its findings of multiple, serious

deficiencies. In order to obtain Medicare reimbursement for patient care, St. Elizabeths Hospital had to submit a plan of correction to CMS outlining how the identified deficiencies would be corrected, with an assurance that the corrections be accomplished no later than November 2, 2004. Tellingly, CMS rejected St. Elizabeths Hospital's first plan of correction, noting that the plans of correction for eight of the thirteen cited deficiencies were unacceptable.

St. Elizabeths Hospital is not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO, an independent organization governed by a board that includes physicians, nurses and consumers, evaluates the quality and safety of care for more than 15,000 health care organizations, including psychiatric hospitals, throughout the U.S.

### **INADEQUATE CLINICAL STAFFING/OVERCROWDING**

The combination of inadequate staffing and overcrowded wards directly affects – and jeopardizes – the patients at St. Elizabeths Hospital. ULS has regularly observed staffing shortages. During a visit to St. Elizabeths Hospital in late September of this year, ULS visited a long-term geriatric ward during the dinner hour. Most of the patients and staff had gone to the dining room. Despite being assigned to provide one-to-one care to a single patient, the lone staff member on the ward was attempting to monitor the activity of at least *six* patients. She acknowledged that she simply could not remain within arm's reach of her assigned patient and provide supervision to the other patients.

Numerous nurses, physicians and nursing aides at St. Elizabeths Hospital, as well as patients and their families, have reiterated and confirmed that the staffing shortage is a pervasive problem. The hospital does not have sufficient psychiatrists, general medical doctors or nurses. Last spring, several wards did not have an assigned psychiatrist, and patients had to rely on “borrowed” psychiatrists, with little or no personal knowledge of the patients and their treatment needs, to sit in on treatment meetings. On some wards, patients went without psychiatric evaluations. In myriad ways, the dearth of psychiatrists greatly impacts the quality and consistency of care at St. Elizabeths Hospital.

On a recent visit by ULS to St. Elizabeths, the nurses reported that they were using restraint and seclusion more frequently, and were administering sedating psychotropic medications as a result of staffing shortages. They also related concerns regarding staff persons who frequently work double and triple shifts due to staff shortages. Night staff, who in many cases have already worked an eight-hour shift or more, frequently sleep while on duty. On one occasion, for example, patients were able to move about the ward during the night without disrupting the four staff who were sleeping soundly in the day room. Without sufficient clinical personnel, St. Elizabeths Hospital simply does not and cannot provide the care so critically important to its patients.

The CMS surveyors also found frequent patient overcrowding and understaffing on the wards, which adversely affects the delivery of nursing services and results in potential safety issues for patients and staff. The CMS surveyors' review of the hospital's census data from April to June 2004 reveals that seventy-five percent (75%) of the units were over census. The CMS report cites multiple instances when the number of nurses assigned to each unit was inadequate and/or the staffing numbers were not increased commensurately when units were over their bed capacity. For example, the report describes a unit with two actively assaultive patients and twenty-two potentially assaultive patients, yet the staffing did not meet the minimum standards outlined in the hospital's own staffing policies. The report also notes that, at times, two geriatric wards with medically fragile patients had five to fourteen patients more than ward capacity, but the staffing was not increased. On yet another ward, the census was eleven patients over capacity and had five potentially assaultive patients, and again the staffing was not increased to handle the increase in patients.

Overall, the number of registered nurses (RNs) assigned to each ward at St. Elizabeths Hospital can be considered well below current acceptable standards. In California, for example, the licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. According to the nursing manual at St. Elizabeths Hospital, the daily nursing standards require only one RN for each unit. With the census of the wards as high as 28 patients at times, the nurse-to-patient ratio is woefully inadequate.

During the CMS visit, the Director of Nursing reported to the surveyors that St. Elizabeths Hospital continues to struggle to meet even the minimum nursing staffing levels: "Staffing is an issue. We have to use overtime shifts to meet our minimum staffing levels. We have filled our last 2 RN positions and have no other positions allowed to hire. Meal breaks are a problem as there is no coverage. The night shift receive no breaks." As a result of these nursing shortages, the CMS audit highlights that the hospital cannot ensure that with each shift change, every ward has immediate RN coverage.

CMS also found that thirty-two percent (32%) of all overtime is used to meet minimal staffing requirements; all vacations, sick time and other absences are covered by regular staff working overtime. The CMS investigation report reminds the hospital what it should already know: constant use of overtime can result in staff fatigue and the failure to provide continuity of care to the patients.

The staff shortages and overcrowding dramatically impact the quality of care provided to patients. Not only does overcrowding create real safety concerns for patients and staff, the patients simply cannot receive appropriate care and treatment on an overcrowded ward. The investigation report cites troubling examples of nurses voicing their concerns to the CMS surveyors about these very issues. For example, a nurse stated that when they are short of staff and she is assigned to care for a patient who requires one-to-one staffing, she has to "drag the patient from room to room as we do total care on the other patients." Another nurse reported that one or two staff persons are frequently

called away from her unit to assist in the “frequent codes in the building”<sup>1</sup> leaving the unit understaffed. Finally, a third nurse explained that when her geriatric ward is over census, she has to “squeeze in a 5<sup>th</sup> bed in a 4 bed room,” which then does not leave room to maneuver the wheelchairs around the room, an obvious safety hazard.

## **DEATHS AND SERIOUS INJURIES RELATED TO STAFFING DEFICIENCIES**

Staffing shortages and inadequate staff training, supervision and intervention have resulted in deaths and serious injuries at St. Elizabeths Hospital.

### **Jane Doe**<sup>2</sup>

According to medical records from St. Elizabeths, in the spring of 2004, an argument began between Jane Doe, an elderly patient on one of the acute care geriatric wards, and another patient on the same ward. The argument escalated into a physical altercation and the patient pushed Ms. Doe, causing her to fall to the floor. No staff person apparently witnessed the incident, despite its occurrence in the ward day room. St. Elizabeths Hospital staff interviewed by the Department of Mental Health’s Office of Accountability reported hearing a loud noise and then seeing the patient on top of Ms. Doe, hitting her with her fists. The medical examiner concluded that Ms. Doe died from a neck fracture. The medical examiner noted that Ms. Doe had a bruise on the center of her forehead and a tooth missing with blood in the socket.

A review of the records and the subsequent investigations by the Office of Accountability and CMS reveals multiple instances of patient neglect before, during and after the incident:

- **Staff failed to properly monitor the patients on the unit.** The Office of Accountability investigation report reveals that the staff persons on duty were not properly monitoring the patients in the day room when the incident occurred. The records indicate that *as many as twenty-one patients were in the day room at the time of the incident, yet no staff person was actually in the day room to witness the incident* or intervene when the argument escalated.
- **Staffing practices placed the patients at risk.** Only one registered nurse was working at the time, with twenty-eight patients on the ward. Two of the five staff persons were working double shifts; two of the five staff persons were covering from other units; only one staff person had been working regularly on the unit.
- **Staff inappropriately lifted Ms. Doe from the floor to a chair after she suffered a trauma to her neck.** All staff should be aware of and trained in the dangers of moving a person who has suffered a head and/or neck trauma. Moving Ms. Doe without stabilizing her neck could have caused more damage to her

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<sup>1</sup> “Codes” denote emergency situations at the hospital requiring additional staff assistance.

<sup>2</sup> All patient names have been changed to protect their privacy.

spinal cord as a result of the neck fracture. In this case, Ms. Doe was found lying on the floor with another patient on top of her, repeatedly hitting her. The proper response would have been to leave Ms. Doe on the floor and immobilize her neck until the paramedics arrived.

- **The nurse on duty did not timely respond to the incident.** The Office of Accountability investigation report reveals that staff called the nurse on duty three times before she responded to their requests for assistance. Moreover, the investigator concluded that the nurse should have been able to see the two women as the incident developed.
- **Staff failed to seek emergency assistance.** The records indicate that the nurse on duty did not call a “code blue,” indicating a medical emergency on the ward, nor did she call 911. Instead, the only registered nurse on the ward waited for the doctor to arrive, despite the fact that Ms. Doe was unconscious and not breathing. Shockingly, her CPR license had expired.

The CMS report determined that St. Elizabeths Hospital failed to adequately follow up on recommendations from the internal investigation examining Ms. Doe’s death, which included examining system-wide staffing shortages.

### **John Smith**

John Smith entered St. Elizabeths Hospital in the spring of 2004. According to the medical records, he was cooperative and appropriate with staff throughout his stay. Three days after admission, another patient stomped on Mr. Smith’s head and face, causing a severe head injury that resulted in a coma.

The St. Elizabeths Hospital medical records contain only two notes describing the incident. Mr. Smith’s records contain no mention of a code 13 – for a behavioral outburst requiring additional staff assistance – or a code blue. The first chart note, entered by the nurse on duty, indicates that the ward staff witnessed the incident from the beginning. The entry describes that Mr. Smith was punched on the head by another patient, which caused him to fall to the floor. The note indicates that the patient started stomping Mr. Smith on the right side of his face and head. The nurse who authored the note recorded that when she arrived, she witnessed the patient “continuously stomping on [Mr. Smith’s] head.” She tried to stop the patient but she failed. She indicates that Mr. Smith was unconscious, bleeding profusely, and turning blue. Her note explains that she checked Mr. Smith’s vital signs; his blood pressure was 78/49 (a very low blood pressure), his pulse was 48 (a very low pulse) and she could not ascertain any breathing. The responding doctor’s note indicates that, on arrival, he found Mr. Smith on the floor moaning and groaning, with blood flowing from his nose and mouth.

The St. Elizabeths Hospital records indicate that two days after the incident, Mr. Smith’s ward doctor received information from Howard University Hospital regarding his condition. The doctor made a note of the conversation in Mr. Smith’s chart,

indicating that Mr. Smith was in the Intensive Care Unit and that he had suffered “severe injury to one eye (rt.) and multiple facial fractures.” The doctor’s note explains that Mr. Smith suffered bleeding in his brain and that he was in a coma.

Mr. Smith was violently attacked by another patient, even while staff witnessed the physical assault from the beginning. From a review of the medical records made available to ULS, nothing indicates that the staff on the ward intervened effectively to stop the assault. It is certainly not clear whether the hospital had adequate staffing on the ward at the time of the incident, whether the staff persons took the appropriate action in response to a patient assault, or whether the staff persons on duty had adequate training regarding physical altercations and appropriate interventions and responses.

### **Robert Jones**

In the winter of 2003, Robert Jones’s condition deteriorated significantly, necessitating his move from a medium security ward at the forensic division of St. Elizabeths Hospital to a maximum security ward. Plagued by visual hallucinations and believing he could end them, Mr. Jones informed the staff, both verbally and through his actions, of his desire to blind himself. Despite the warnings, in the spring of 2003, while under a physician’s medical order both to be placed in four-point restraints and assigned one-to-one staff supervision, Mr. Jones removed both of his eyes with his hands.

In the days preceding the injury and for months afterward, Mr. Jones spent most of his time – day and night – in restraints. On several occasions, a single period of restraint lasted over a month. Moreover, St. Elizabeths Hospital did little to reassess Mr. Jones’s treatment needs and effective medications. Not until almost nine months later, following ULS advocacy, did the hospital change Mr. Jones’s treatment regimen, including his medications.

The Department of Mental Health’s Quality Improvement Director conducted an investigation after Mr. Jones’s self-injury. The investigation report is replete with the hospital’s failures, including supervisory, training and staffing deficiencies, as well as quality improvement failures. The report found numerous instances when staff had not complied with the hospital’s own policies, especially the rigorous requirements of the Mandatory Guidelines on Restraints and Seclusion, violation of which automatically constitutes patient abuse. From ward staff through the Associate Director of Medical Affairs, St. Elizabeths Hospital deviated from a policy designed to protect the health and safety of patients whose behavior might need to be addressed temporarily through seclusion or restraint. Most distressing, the investigation report highlights a systemic failure: St. Elizabeths Hospital did not have a Director of Quality Improvement or a Quality Improvement Committee to investigate Mr. Jones’s particular incident or engage in the larger task of analyzing trends and patterns of violent incidents.

## **FAILURE TO PROVIDE MEDICAL RESOURCES**

According to St. Elizabeths Hospital records and information provided by staff to ULS, the hospital discontinued all physical therapy services in February 2003. There are, however, patients who have physical conditions, in many cases requiring the use of wheelchairs, whose health and safety are at risk without these vital services. The hospital no longer provides physical therapy on its grounds and does not make off-site services available to its patients. Shockingly, the lack of physical therapy services can be connected to at least two deaths.

### **John Doe**

According to the death certificate, John Doe died in late 2003 of a pulmonary embolism due to immobility following a head injury. A pulmonary embolism occurs when a blood clot forms, usually in the legs, and travels to the lungs, interfering with the body's ability to breathe. St. Elizabeths Hospital discontinued Mr. Doe's physical therapy services over one year before his death and they were never again provided, despite written warnings from his doctors that his health was deteriorating.

Mr. Doe used a wheelchair after a head injury in 1977 caused an imbalance problem. The physical therapy services enabled him to keep his legs strong enough to ambulate at least two or three times a week during physical therapy. The physical therapy services were critical to improving the circulation in his legs. His doctors knew this and urged that Mr. Doe receive the necessary treatment. Without physical therapy, Mr. Doe developed blood clots in his legs, which ultimately may have caused his death.

### **Don Smith**

Don Smith died several months ago. Although ULS has been unable to obtain an autopsy report, the St. Elizabeths Hospital medical records reveal that Mr. Smith's doctor suspected that he too died from a pulmonary embolism.

Mr. Smith also used a wheelchair. In early spring 2004, Mr. Smith's psychiatrist recommended during a case conference that he receive a physical therapy evaluation. Specifically, the conference notes indicate that Mr. Smith would benefit from physical therapy services. Two months later, the notes from another case conference state that Mr. Smith's team members reached a consensus that he needed physical therapy services to maintain his health and to give him the opportunity to ambulate. Mr. Smith never received the recommended physical therapy services. He died the following month, most likely from a pulmonary embolism that physical therapy services might have prevented.

## **INADEQUATE AND INAPPROPRIATE TREATMENT**

Through its representation of individual consumers at St. Elizabeths Hospital and its federally mandated monitoring activities, University Legal Services has found an alarming absence of meaningful, therapeutic programming that emphasizes a recovery model. Instead, clinical staff rely on the outmoded medical model of treatment, which advocates a “doctor knows best” approach, to create plans for patients that are neither individualized nor treatment or recovery-oriented. In many instances, treatment planning occurs without the patient’s input, and even when specific, individualized treatment recommendations are made, they are often ignored. This “disconnect” between the clinical staff and the patients is even more egregious when a patient’s English language skills are limited. The CMS surveyors found that St. Elizabeths Hospital did not provide interpreters to both of the randomly selected patients with language barriers. Thus, these patients could not have benefited significantly from any interventions.

In almost half of the sample patients CMS reviewed, St. Elizabeths Hospital failed to develop and document individualized, comprehensive treatment plans based on the patients’ presenting problems and needs. Moreover, for eleven of twelve sampled treatment plans, the hospital’s failure to develop measurable short- and long-term goals resulted in a larger failure to provide a basis for purposeful, goal-directed treatment. CMS also found that St. Elizabeths failed to implement the individual treatment plans for the patients the surveyors reviewed at random, and the investigation report revealed that the hospital failed to provide needed programming for all of the patients on a particular ward unit who had significant behavior problems. Moreover, the CMS investigation report details the lack of active treatment on the wards. For example, during a ward visit at 2 p.m., the CMS surveyors found “There were 15 patients in the dayroom area with 5 patients sitting in chairs, 4 patients ‘milling’ about the dayroom, 2 patients sitting talking to themselves, and 4 patients sitting side by side in chairs ....”

ULS has regularly observed that the hospital offers little in the way of active treatment on the wards. In many instances, patients simply sit idle without adequate structure or supervision. Most patients do nothing; they often just stare into space, sleep or occasionally talk to themselves. The only reliable activity seems to be television, if it is not broken. The hospital does not appear to offer patients reading materials, games or playing cards. In fact, the “libraries” on the wards have been converted to meeting rooms and staff lounges. Because the hospital lacks sufficient staff, patients’ opportunities to go outside are limited; no one is able to accompany patients on the grounds for fresh air or exercise. Little is done to encourage interaction with staff or with other consumers. In fact, it is almost universally true that the staff remain behind the nurse’s station. When there are many patients on a ward, there is often a lot of yelling, many times by the staff directed at patients.

Similarly, the CMS surveyors found that the hospital failed to provide appropriate therapeutic activities for all patients on the weekends and evenings. The lack of planned activities, therapy and recreational opportunities undermines the reason that the patients

were sent to St. Elizabeths in the first place – to provide treatment to hasten the improvement of mental illness symptoms.

## **OVERUTILIZATION OF SECLUSION AND RESTRAINT**

The hospital has a history of relying on seclusion and restraint, often for lengthy periods of time, to manage “problem” patients, without exploring alternative behavioral interventions and modalities. As the Department of Mental Health’s Office of Accountability has explained, “consensus professional opinion, best practice standards and hospital policy suggests that the use of restraints should be considered for emergency purposes only and to be short-term in duration. The long-term use of restraints would not, therefore, be considered an “appropriate” long-term treatment-of-choice for any patient.” Unfortunately, actual practice at the hospital often does not reflect best practice.

Between December 1, 2002, and November 30, 2003, 116 incidents of seclusion or restraint lasted twenty-three hours or longer, in violation of the hospital’s own mandatory policy on seclusion and restraint and the recently passed seclusion and restraint legislation in the District of Columbia. Unbelievably, in six cases the seclusion or restraint period exceeded one month.

More recent information regarding seclusion and restraint use at the hospital reveals that although utilization for periods longer than twenty-three hours has decreased, the practice continues. Between December 1, 2003, and July 27, 2004, ten patients were restrained in four-point restraints for more than twenty-three hours, and two patients were secluded for more than twenty-three hours. Other violations of the seclusion and restraint policy surface in the CMS report. For example, even when a patient is lying quietly or has fallen asleep, and the acute episode has ended, seclusion or restraint often continues.

## **PATIENTS’ SUBSTANDARD LIVING CONDITIONS**

Although the hospital has an obligation to provide safe, sanitary living conditions for its patients, the physical plant and conditions on the wards are substandard. Staff lack the necessary basic resources, such as soap and paper towels, to perform their jobs well. Patients lack adequate personal hygiene supplies. Staff also reported that they did not have enough blankets or clothing for their patients. The CMS report cites concerns from two mental health workers who stated that they only had twenty-five gowns for twenty-six incontinent patients on their unit and that they were unable to get more. Wards often smell of urine and other bodily excretions. Rats and mice share space with the patients and staff. One patient complained recently that he had to throw away his winter coat because it had become a rats’ nest. Even as recently as last week, one patient reported that a ward had been without hot water for the entire week.

Such unsanitary conditions not only lead to an unpleasant environment, but also expose already vulnerable individuals to the spread of contagious, communicable illnesses such as influenza and tuberculosis, as well as unwarranted stress and additional health risks.

## **DEFICIENT QUALITY ASSURANCE AND IMPROVEMENT EFFORTS**

In order to provide high quality medical care, a hospital must have a well-defined, functioning quality assurance program. The care a patient receives in a health care institution reflects a combination of efforts by both the institution and the individual clinicians. When serious incidents arise or treatment is ineffective, both the hospital and its physicians must determine the cause of the problem, also known as “root cause analysis,” and arrive at solutions that will prevent its reoccurrence. The quality assurance program must conduct case reviews to determine institutional system failures as well as practitioner problems. When system failures are identified, the institution must implement corrective action plans, and the outcome of these plans must be made available to the clinical staff as well as the patients affected.

Unfortunately, St. Elizabeths Hospital lacks the necessary financial and personnel support to ensure that the medical staff can implement a quality assurance program. Until very recently, the hospital did not even engage in quality assurance and improvement activities, loosely maintaining only its Mortality and Morbidity Committee. During the CMS complaint audit, the St. Elizabeths Hospital Administrator explained that the hospital was in the process of *establishing* a performance improvement plan, and only “bits and pieces” were in place. Hence, when the Mortality and Morbidity Committee recommended that the quality improvement department review Ms. Doe’s death as a systemic problem, the recommendation went unheeded. As the CMS surveyors found, issues that are identified as important to the hospital’s functioning are not acted on, making improvement nearly impossible.

Based on a review of death records, Mortality and Morbidity Committee minutes and staff interviews, CMS found that clinical director failed to ensure that the hospital adequately monitored deaths and other serious events. For example, the Mortality and Morbidity Committee determined that a patient who died was prescribed a medication that had strict national protocols for frequent blood tests, but the patient had not had the necessary blood tests for two years. This finding especially troubled CMS because this particular medication is known to potentially cause death if the patient is not closely monitored. The CMS report found that even after the patient’s death, St. Elizabeths Hospital’s clinical staff had taken no remedial action to guard against this dangerous situation reoccurring.

In yet another troubling case, the CMS surveyors also found that the Morbidity and Mortality Committee had concluded that a former patient died when a local hospital discharged him back to St. Elizabeths before he was medically stable. The clinical director acknowledged to the surveyors that premature discharge from area hospitals was

an ongoing concern that had also occurred in the past, but St. Elizabeths Hospital had not taken any steps to address the problem.

### **ST. ELIZABETHS HOSPITAL'S RESPONSE TO THE CMS AUDIT**

CMS gave St. Elizabeths Hospital until November 2, 2004 to achieve compliance with the federal conditions of participation in the Medicare and Medicaid program. In late September, the hospital initiated a dramatic reorganization of the patients, dividing them between paying and non-paying wards. In other words, those patients for whom St. Elizabeths Hospital can receive reimbursement, and for whom CMS will continue to exercise oversight, have been grouped together on four wards, while the non-paying patients, or those whose care the District of Columbia is wholly financially responsible for, are on separate wards. Patients, their families and guardians were not informed about the drastic upheaval, forcing confused patients to stand outside in the rain holding their meager belongings while they and their medical records were relocated. When CMS returns to St. Elizabeths to once again assess the conditions of care, will the surveyors only view the paying patients' wards? Who will assess the conditions of the non-paying wards?

The medical staff recognize the hospital's continued inability to provide appropriate care. When asked about the hospital's failure to assess patients' strengths to be used in therapy, the clinical director honestly acknowledged the facility's ongoing deficiency: "[Treatment plans] need to be written in a better way. When HCFA [CMS's predecessor agency] came in last year we had the same issue." Given St. Elizabeths Hospital's previous failures to meet federal standards of care, the conditions at St. Elizabeths Hospital are not likely to improve without additional expert attention and monitoring.

### **CONCLUSION**

The Department of Mental Health and St. Elizabeths Hospital must improve conditions immediately. Patients' lives are in peril. This report highlights numerous conditions that must be rectified. Staff need greater support and the resources necessary to perform their duties effectively. Quality assurance programs are vital to the health and safety of the patients. St. Elizabeths needs an effective and autonomous clinical staff to monitor and improve the level of services provided to patients. To ensure patients are no longer subject to abuse and neglect, St. Elizabeths must create and provide ULS and the community with meaningful performance indicators that demonstrate actual improvements in the quality of care. The community and the consumers deserve a mental health hospital with a safe, sanitary and therapeutic environment that fosters healing. These very serious problems must be addressed and this very vulnerable population cared for.

## History and Authority of University Legal Services

In 1996, ULS was designated the protection and advocacy (P&A) program for the District of Columbia. The federal P&A laws require ULS to investigate allegations of abuse and neglect of people with disabilities. Accordingly, ULS provides administrative and legal advocacy to protect the legal and human rights of individuals with disabilities. Congress vested the protection and advocacy program with authority under the following statutes: Protection and Advocacy for Individuals with Mental Illness Act (PAIMI); the Protection and Advocacy for Developmental Disabilities Act (PADD); and the Protection and Advocacy for Individual Rights Act (PAIR).

ULS staff directly serve hundreds of individual clients annually, with thousands more benefiting from the results of investigations, class action litigation and group advocacy efforts. ULS staff address client issues relating to the improper use of seclusion, restraints, medication, abuse and neglect, community integration, wraparound services, accessible and affordable housing, financial exploitation, access to health care services, individual choice, employment, benefits, special education, and the care and treatment of people with disabilities.