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

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VIA ELECTRONIC MAIL AND FIRST CLASS MAIL

Ms. Ellen A. Efros, Esq.
Assistant Attorney General
Equity Section I
Civil Litigation Division
Office of the Attorney General
Government of the District of Columbia
441 4th Street, NW
6th Floor South
Washington, DC 20001

Re: St. Elizabeths Hospital

Dear Ms. Efros:

We write to provide you with our findings regarding our compliance visit to St. Elizabeths Hospital ("SEH") on February 11-15, 2008. As an initial matter, we would like to thank you and the administration and staff at SEH for the cooperation we received during our tour. We wish to extend special appreciation to Department of Mental Health Director Stephen Baron, Chief Executive Officer Patrick Canavan, Medical Director Dr. Alberto Fernandez-Milo, and Compliance Officer Janet Maher for their hospitality, assistance, and professional conduct before, during, and after our tour.

As you know, this was our first visit conducted in accordance with the Settlement Agreement ("SA") between the United States and the District of Columbia regarding conditions at SEH. Because it was our first visit, our findings and the attached joint report of our expert consultants will serve as the "baseline" from which we will measure future progress and compliance with the Settlement Agreement. Our expert consultants were instructed to provide compliance findings for each provision based on three levels of compliance: 1) Substantial Compliance: substantial compliance with all components of the relevant

provision (e.g., 95-100%); 2) Partial Compliance: although substantial work remains, substantive progress has been made with substantive key components of the relevant provision; and 3) Noncompliance: noncompliance with most or all of the substantive key components of the relevant provision. Please note that these levels of compliance are not mathematical formulas and we will take into consideration the subjective and/or objective measures that may be applicable to the relevant provision. In addition, the final assessments of the District's compliance with the Settlement Agreement provisions will be informed by our consultants, but made by the Department of Justice.

You will see that the attached joint report ("Report") is over 200 pages, as it incorporates the work of all four expert consultants. In this letter, we hope to provide you with an overview of our general findings and comments regarding the broad topic areas of the Settlement Agreement. In addition, SEH administration and officials have asked for guidance regarding the prioritization of certain provisions and reforms. Accordingly, the specified time periods within the Settlement Agreement notwithstanding, we have highlighted below some recommendations that SEH and the District should address and the areas in which progress should be shown by the time of our next compliance visit later this year.

I. Protection From Harm and Risk Management

First and foremost, we are alarmed and deeply concerned over the significant number of recent deaths at SEH and the inadequate nursing and medical care that these deaths have highlighted. Our concern is further heightened by our analysis of the critical deficiencies in SEH's death reviews and mortality review system. It is imperative that SEH and District of Columbia officials place such issues of harm as a priority and at the forefront of their reform efforts. Moreover, in addition to receiving notice of any deaths and serious injury at SEH, we also expect to receive on a timely basis any completed incident reports related to deaths and serious injury, autopsies and/or death summaries of residents, as well as all final reports of investigations as outlined in Section XVI.E. of the Settlement Agreement.

With regard to the overall category of protection from harm (Section XI. of SA), SEH is in noncompliance (Report p. 170). Although, many of the subprovisions under incident and risk management (Sections XII.A.-XII.E. of SA) are in partial compliance (Report pp. 171-191) because SEH has begun creating appropriate policies and procedures to address incident and risk management, implementation of the policies and procedures remains

a challenge. Consequently, SEH is in noncompliance with this Section of the SA because of the absence of any corrective actions-a fundamental and necessary component of any risk management system.

The following are some recommendations that we highlight from the Report for SEH to prioritize before our next compliance visit:

1. Develop and implement a mortality review system that ensures that death reviews are timely, thorough and complete, contain specific recommendations for corrective action, and that such actions are implemented. (Section VIII.A.2.b.iv. of SA and Report p. 110).

2. Revise the hospital's incident database so that, at a minimum, the database includes individuals' names and is capable of producing reports that identify individuals who are repeat aggressors and victims. (Section XII. and Report p. 191). In addition, SEH and the Department of Mental Health should establish a set of definitions of incident types with corresponding codes to be incorporated into revised policies and reflected in a revised incident reporting form. (Section XII. of SA and Report p. 185).

3. Train staff to address and prevent under-reporting of abuse and neglect. (Section XII. of SA and Report p. 175).

4. Provide individuals with adequate clean clothing, bedding, and personal hygiene items. (Sections XI. and XIV. of SA and p. 204).

II. Nursing Care

With regard to the overall category of nursing and unit-based services (Section VIII.D. of the SA), SEH is in noncompliance (Report pp. 130-151). We are particularly concerned with the insufficiency of nursing staff necessary to provide SEH patients with basic nursing care and services (Section VIII.D.11.). Indeed, the shortage of nursing staff, as well as the dearth of Registered Nurses on all of the units pose significant health and safety risks to the patients, particularly on the units with a number of patients with compromised and unstable medical conditions. (Section VIII.D.11. and Report

p. 149). This is also an issue that we believe may have significantly affected the number and manner of deaths at SEH last year. Noncompliance with this overall category notwithstanding, SEH has made some notable strides in the areas of monitoring, documenting, and reporting the administration of medications and the beginning steps of an infection control program. (Sections VIII.D.3.-6. and VIII.D.10.a., c., and g., and Report pp. 135-138).

The following are some recommendations that we highlight from the Report for SEH to prioritize before our next compliance visit:

1. Clarify nursing leadership structure/roles, fill key nursing leadership positions, and develop an organized staffing plan for each unit that specifies by shift the total numbers of positions as well as the skill mix. At a minimum, an RN must be on duty on each unit at all times (24/7). (Section VIII.D.11. of SA and Report pp. 149-150).

2. Discontinue current Nursing Diagnoses and develop and begin training on a more appropriate assessment tool integrated more fully into the treatment planning process that addresses the following minimum priority areas: a) psychiatric/ mental health concerns and diagnoses, related symptoms, and interventions; b) medical/health and wellness concerns; and c) danger to self or others. (Sections VIII.D.2. and VIII.D.9.a. of SA and Report pp. 135 and 141).

3. Develop/revise policies for RNs to communicate with physicians in the following situations: a) medical and behavioral emergencies; b) transfers to and from other treatment settings; and c) reporting/acting on changes in physical conditions. (Section VIII.D.3. of SA and Report p. 136).

4. Provide clear direction and accountability in the written Infection Control Program, including implementing processes to address tuberculosis and outbreaks associated with food borne illnesses, norovirus, and the flu. (Section VIII.D.10. of SA and Report pp. 148-149).

III. Treatment Planning and Psychiatric Care

With regard to the overall category of treatment planning and psychiatric care (Sections V.A., VI, and VIII.A. of SA), SEH is in noncompliance (Report pp. 1-67, 93-114). As with nursing, we are particularly concerned with the insufficiency of psychiatry staff necessary to provide SEH patients with basic psychiatric care and services. However, we commend SEH for the significant strides made in the areas of psychiatric assessments and diagnoses (Sections VI.A.3-7. of SA and Report pp. 60-67). Again, similar to the other overall categories of the SA, many fundamental steps, such as development of policies, procedures and training, have begun, but implementation and consistency with meeting established policies and procedures remain in the coming months.

The following are some recommendations that we highlight from the Report for SEH to prioritize before our next compliance visit:

1. Develop and implement corrective actions to ensure that an initial psychiatric assessment is completed within 24 hours of admission and a comprehensive psychiatric assessment is completed within four business days of admission. (Section VI.A.1. of SA and Report pp. 56-58).

2. Develop and implement corrective actions to ensure adequate risk assessment of individuals upon admission to the facility. At a minimum, the assessment must provide information regarding: a) type of risk (e.g., suicide, homicide, physical aggression, sexual aggression, self-injury, fire setting, elopement, etc.); b) timeframes for risk factors; c) description of the severity of risk and its relevance to the danger of harm; and d) a review of the circumstances surrounding the risk events, including mitigating factors. (Section VI.A.2. of SA and Report pp. 59-60).

3. Develop and implement training programs to ensure proper implementation of the process and content of individualized, integrated and recovery-focused treatment planning. The programs must include the following areas: a) team leadership skills; b) engagement of individuals; c) case formulation, foci, objectives and interventions, stages of change; and d) discharge planning. (Section V.D.1. of SA and Report pp. 39-40).

4. Organize treatment planning meetings around a template that includes:

   a) interdisciplinary assessment of the individual's mental illness, including the predisposing, precipitating and perpetuating factors relevant to that illness; b) current interdisciplinary reporting on the assessment of the individual's present status, including symptom status, current interventions, responses to interventions, and adjustments to treatment and risk factors; c) discharge readiness and barriers to discharge; d) medication side-effects; and e) if applicable, the role of token economies and behavioral guidelines/positive behavior support plans in establishing and maintaining wellness. (Section VI.A.2.a. of SA and Report pp. 6-7).

5. Develop and implement corrective actions to ensure that individuals receiving high risk medications are properly monitored for the risks of treatment and that appropriate attempts are made to utilize safer and effective treatment alternatives. In addition, SEH should develop and implement mechanisms to ensure that adverse drug reactions and medication variances (errors) are properly captured, reported, investigated and analyzed and that corrective actions are implemented to address problematic trends and to reduce the risk for the individuals. (Section VIII.A.2.a.i. of SA and Report pp. 102-103).

IV. Behavioral Management and Psychological Care

With regard to the overall category of behavioral management and psychological care, including discharge planning and community integration (Sections V.A., VI.C., VI.D., VII., and VIII.B. of SA), SEH is in noncompliance (Report pp. 1-15, 77-91, and 115-127). However, we commend SEH for reaching substantial compliance with the following subprovisions in this category: Sections VI.B.2.a., VI.B.2.c., and VIII.B.4.d. It should be noted that risk assessments, when requested, were appropriately administered for risk of harm factors (Report p. 72). Thus, SEH has the fundamental tools to conduct adequate risk assessments, and the shortfalls in the other relevant areas of risk assessment that were in noncompliance (e.g., Sections VI.A.1., VI.A.2., VIII.D.9.a. of SA) are primarily due to the absence of routine and timely risk assessment procedures and protocols.

The following are some recommendations that we highlight from the Report for SEH to prioritize before our next compliance visit:

1. Develop and implement a template for all mall treatment groups/individual therapies that provides treatment teams with timely documentation of the individual's progress toward attainment of short term goals in mall treatment groups. The template should identify when treatment has been successful, requiring implementation of the next step in treatment or when treatment has been unsuccessful, requiring further assessment and/or a change in treatment. (Sections V.A.2.c., V.D.4., VIII.B.4.f. of SA and Report pp. 8, 43, and 126).

2. Develop and implement auditing tools for all discipline-specific assessments in Psychology, Social Work, and Rehabilitation Therapy as detailed in the individual recommendations appropriate to each of the above discipline sections of the full report. (Sections VI.C.1., VI.D., and VIII.B.1.a. of SA and Report pp. 77-78, 80-81, 116-117).

During our discussions and meetings prior to and during our compliance visit, we discussed the requirements of the "Corrective Action Plan" or "CAP" under the SA. Instead of SEH providing a CAP based on the four "Benchmark" areas outlined in Section XV. of the SA, we suggest that you review our Report and that you outline the corrective actions you intend to take to respond to the specific recommendations outlined in the Report within ninety (60) days of receiving the Report. The responsive corrective actions should include the information outlined in Section XV of the Settlement Agreement: 1) the action steps to be taken to adequately comply with the recommendations; 2) the timeline to achieve the action steps; 3) the person(s) responsible for implementing the action steps; 4) the status of the action steps along with quality assurance mechanisms to evaluate and monitor such status; and 5) the documents that demonstrate progress and/or compliance with the particular recommendation.

The number of provisions in non-compliance notwithstanding, we acknowledge and appreciate the fact that this is a baseline tour and fully implementing the Settlement Agreement will take both time and effort. Again, we appreciate the challenges that SEH administration and staff face in implementing the numerous

provisions of the SA. We remain committed to assisting SEH and working with District officials in achieving compliance in accordance with the terms and timelines of the SA.

We hope that the foregoing and the attached Report are viewed in a constructive light and will assist the ongoing efforts to complete implementation of the SA. We look forward to touring SEH this fall to reassess SEH's compliance status. As always, we remain available to discuss any questions or concerns that you might have regarding our review. If you have any questions, please do not hesitate to contact me at (202) 514-0195, or the attorneys assigned to this matter Je Yon Jung at (202) 305-1457 or William Maddox at (202) 514-6251.

Sincerely,

Shanetta Y. Cutlar
Chief
Special Litigation Section

Enclosure