U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

March 17, 2004

The Honorable Michael F. Easley
Governor of North Carolina
116 West Jones Street
State Capitol Building
Raleigh, NC 27603

Re: North Carolina's Public Mental Health Hospitals, Dorothea Dix Hospital in Raleigh, Broughton Hospital in Morganton, Cherry Hospital in Goldsboro, and John Umstead Hospital in Butner

Dear Governor Easley:

On June 20, 2001, we notified you that we were initiating an investigation of conditions at North Carolina's four state-operated mental health facilities (Dorothea Dix, Broughton, Cherry, and John Umstead Hospitals) pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.

During the spring to early summer of 2002, we visited all four facilities with expert consultants in the areas of psychiatry, psychology, nursing care, social work, substance abuse, community mental health care and discharge planning. We conducted our investigation by reviewing facility records, including patients' medical charts and other documents relating to the care and treatment of patients, interviewing administrators, staff, and patients, and conducting on-site tours of all four hospitals. At exit interviews conducted on the last day of each facility visit, we verbally conveyed our preliminary findings to counsel, senior North Carolina Department of Health and Human Services officials, and supervisory facility administrators. Consistent with the requirements of CRIPA, we are now writing to apprise you of our findings. Our findings are supported by the assessments contained in our expert consultants' reports.

As a threshold matter, we wish to express our appreciation to the staff of the Department of Health and Human Services, the

Attorney General's office, and the administrators and staff of the four facilities for their extensive assistance and cooperation during our investigation. Further, we wish to note that the four facilities are staffed predominately by dedicated individuals who genuinely are concerned for the well-being of the persons in their care. We hope to continue to work with state officials and the administrators at Dorothea Dix, Broughton, Cherry, and John Umstead Hospitals in the same cooperative manner in addressing the problems that we found.

I. BACKGROUND

A. Facility Descriptions

North Carolina has established a state hospital system in which all public in-patient mental health care is provided at four state psychiatric hospitals.

Founded in 1856, Dorothea Dix Hospital is the State's oldest psychiatric hospital. Dix provides in-patient psychiatric care to residents of 16 counties comprising the south central region of North Carolina, including the Raleigh-Durham area. The region is also serviced by eight community "area programs" responsible for mental health services.[1] Dix has a capacity of 494 patients although, at the time of our tour, the census averaged between 330 and 350 patients per day.

Cherry State Hospital, which opened in 1880, provides in-patient psychiatric care to residents of 33 counties in the eastern region of North Carolina, and is serviced by 13 area programs. Cherry currently has a capacity of 478 beds but its average daily census at the time of our tour was 454 patients.

Broughton Hospital, which the State opened in 1882, provides in-patient psychiatric care for 37 counties in the western region of North Carolina, and is serviced by 38 area programs. Broughton has a capacity of 431 beds although its average daily census at the time of our tour was 410 patients.

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[1] Area programs are the state-mandated, community-based, mental health and substance abuse authorities that provide outpatient services to the patients hospitalized at the respective four state psychiatric hospitals and to where the majority of the patients are referred for services upon discharge. The relationship between the area programs and the hospitals is mandated by state code and based on formal letters of agreement between the entities.

Finally, John Umstead Hospital, opened in 1944, serves 14 counties in the north central area of North Carolina, and is serviced by seven area programs. Umstead has a capacity of 593 beds even though its census at the time of our tour was just 421 patients.

Each hospital serves a variety of populations, including adults with acute and long term care needs, children, adolescents, the elderly, and individuals with substance abuse problems. Two of the hospitals, Umstead and Dix, operate medical/surgical units. Umstead also operates a forensic unit and a unit for persons who are hearing impaired. The state hospitals admitted over 16,000 patients in 2001 and have a combined staffing of approximately 5,300 positions.

B. Legal Background

We have evaluated whether patients are receiving care and treatment in accordance with their constitutional and federal statutory rights at the four facilities. Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with habilitation to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg v. Romeo, 457 U.S. 307 (1982); Patten v. Nichols, 274 F.3d 829 (4th Cir. 2001). Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions). The State is further obliged to provide services in the most integrated setting appropriate to individuals' needs. See Olmstead v. L.C., 527 U.S. 581 (1999).

II. FINDINGS

Our investigation revealed a number of constitutional and federal statutory violations at the four facilities, including: (A) inadequate mental health treatment; (B) inappropriate use of restraints and seclusion; (C) inadequate nursing and medical care; (D) failure to ensure the reasonable safety of patients; (E) unsafe physical plant conditions; and (F) inadequate discharge planning, as evidenced by the failure to provide services to discharged patients in the most integrated setting. A major cause of many of the unlawful conditions we identified stems from a fragmented, decentralized mental health system with unclear, unspecified standards of care, and an insufficient number of adequately trained professional and direct care staff to meet the needs of patients. The facts that support our

findings are set forth below, followed by recommended remedial measures that we believe are necessary to correct these conditions. The findings apply to all four facilities unless otherwise indicated.

A. Failure To Provide Adequate Mental Health Treatment To Patients

The mental health services that North Carolina is providing to patients at its psychiatric hospitals substantially departs from accepted professional standards. Psychiatric practices at all four hospitals are marked by inadequate assessments and treatment planning, inadequate care for patients with specialized needs, inadequate psycho-social rehabilitation services, and inadequate psychopharmacological practices.

1. Inadequate Assessments and Treatment Planning

Treatment plans are critical to the functioning of psychiatric hospitals. In accordance with generally accepted professional practice, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. The treatment plans should define the goals of treatment, the interventions to be utilized in achieving these goals, and ways in which various staff engaged in the provision of services are to coordinate treatment. The treatment plans should also detail the integrated plan of care or treatment designed to promote the patient's stabilization and/or rehabilitation such that the patient may return to the community. On an aggregate basis, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are pivotal to a hospital's ongoing efforts at performance improvement.

North Carolina generally fails to assess appropriately its patients' mental health needs and fails to develop and implement adequate treatment plans to address specific needs. The existing treatment plans often are not individualized, lack essential elements, and are not implemented consistently. Nor do assessments identify and prioritize specific mental health problems and needs. Rather, many of the treatment plans reviewed simply include vague and often overlapping goals and objectives that provide little assistance in directing staff activity and establishing a coordinated approach to treatment. The plans frequently set forth generic interventions, and patient problems are identified with no indication that they were being addressed in a timely or meaningful way.

Inadequate assessments and treatment planning harm patients receiving care in North Carolina's four psychiatric hospitals by subjecting them to needless medications and their attendant side effects. In addition, by failing to treat the underlying mental illness adequately, patients are exposed to uncontrolled negative behaviors and otherwise unnecessary re-admissions. Moreover, inadequate treatment planning and patient idleness may exacerbate mental illnesses and serve to make patients more withdrawn, aggressive, or suicidal -- all of which present direct threats to patient health and safety.

Another fundamental deficiency with the State's patient treatment planning is that it is not interdisciplinary. Effective treatment planning integrates the observations and interventions of professionals from different disciplines to develop a cohesive plan to meet the patient's particular needs. Yet the treatment planning in North Carolina reflects a clinical process in which different professional disciplines operate independently and fail to communicate adequately. Staff do not share critical information or coordinate treatment efforts, and attempts to monitor and evaluate the quality of services have been haphazard at every level.

Treatment planning at three of the hospitals, Umstead, Broughton, and Dix, relies for the most part on check-box systems: hospital staff are provided with pre-printed lists of generic statements regarding patient problems and symptoms, and treatment goals and interventions, and staff then check those boxes that are relevant to a particular patient. Although a check-box system may form the basis for individualized treatment plans, at Umstead, Broughton, and Dix, the generic statements checked for each patient often are not amplified with any specific information about the particular patient. The checklists also are not integrated into a single coherent plan and, as a result, hospital staff must flip between various pieces of paper and then mentally string together the information that is provided.

For example, for Umstead patient Rolanda S.,[2] diagnosed with post-traumatic stress disorder, schizoaffective disorder, and borderline personality disorder, the following items are checked on the treatment plan form: "refrain from acting on

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[2] We have assigned random names to the patients mentioned herein to protect their privacy. In a separate transmittal, we are providing a schedule which identifies these individuals.

hallucinations/internal stimuli;" "acknowledge and discuss maladaptive patterns of coping and effect this has on life;" "work with team to establish living situation;" and "participate in Psyh Rehab skills group." In addition, staff added one notation, "will not gain weight." This information does not provide an objectively measurable course of treatment tailored to the patient's needs. Similarly, the plan for Umstead patient Brenda W., diagnosed with paranoid schizophrenia, identifies short-term and long-term goals that not only are largely identical, but also are so general in nature as to provide little useful information (e.g., the plan states that she should decrease her aggressive behavior and refrain from acting on her hallucinations and delusions).

At Dix, when staff write in additional information on the check-box forms, they often simply reiterate the pre-printed information that was checked. In addition, staff members occasionally cross out and write over their notations, without explanation as to why the change was made and without indicating the date of the change. For example, in the treatment plan for Lisa B., the notation that she has "self-injurious behavior" is crossed out and "legal charges pending on bad check writing" is written over this, without any explanation as to why the latter had replaced the former and no indication as to when this occurred.

Treatment planning at Cherry, although not reliant on a check-box system, suffers similar problems. For example, the treatment plan for Brian B. includes the following goals and strategies for addressing his suicidal ideation: "patient will no longer be suicidal and will have a more positive outlook on life;" "patient will report during two fifteen minute interactions with staff per week that he no longer feels suicidal and feels better about himself;" and "patient will demonstrate use of distress tolerance and emotional regulation skills in dealing with distress and emotional suffering once per week." The plan directed the staff to "assess for level of depression and suicidality and report to MD if necessary." These goals are vague and non-measurable with no specified interventions to address the problems identified.

The difficulties with treatment planning at Cherry are exacerbated by poor diagnostic practices. While establishing a precise diagnosis is a fundamental first step in developing an appropriate plan of treatment and a cornerstone of generally accepted professional practice, Cherry clinicians continue to offer treatment in the absence of a definitive diagnosis. Specifically, an unusually large number of Cherry patients (about

one-third of the cases reviewed regarding treatment planning) have diagnoses of psychosis, mood disorder, or personality disorder identified as "NOS" ("not otherwise specified"), often for extended periods of time. An initial NOS diagnosis should lead to further assessment to establish a definitive diagnosis, but it appears that this is often not done.

Professionals at the four facilities seem to recognize that their respective treatment planning processes are significantly flawed and in need of serious reform. At Umstead, a memorandum dated January 25, 2002, from Dr. Harold Carmel (Clinical Director) and Patricia Christian (Chief Executive Officer) to all the unit clinical directors, unit administrative directors, and hospital discipline heads, states:

> [I]t is now the time to review and revise our treatment planning documentation, doctrine and practice. Treatment teams need to be interdisciplinary rather than multidisciplinary....Treatment planning, processes, policies and forms need to be updated to make goals and objectives clearer, to expedite individualization, to expedite linking identified problems with promised interventions, to expedite identifying which treatment interventions and observations are linked to which identified problems, and to expedite the ongoing process of revising treatment plans in view of the patient's response to treatment.

At both Broughton and Cherry Hospitals, in response to deficiencies cited by Centers for Medicare and Medicaid Services' ("CMS") surveys,[3] hospital officials acknowledged that revisions to the treatment planning process are necessary.

Similarly, at Dix, professionals acknowledged a widespread absence of individualization in treatment planning. As discussed above, this is largely the result of Dix's decision to reduce treatment planning to a series of pre-printed generic lists and check-boxes. As noted by the hospital's Treatment Planning Committee in March 2002:

> We don't do treatment planning. We just fill out forms....Current forms make it

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[3] See CMS March 2002 survey of Broughton Hospital, and Broughton's May 2002 Plan of Correction; CMS February 2002 survey of Cherry Hospital, and Cherry's May 2002 Plan of Correction.

virtually impossible to individualize plans.

While we find that treatment planning generally does not meet generally accepted professional standards, we acknowledge that efforts are underway to improve treatment planning in North Carolina. We plan to assess the effectiveness of these reforms in correcting the treatment planning deficiencies we have identified.

2. Inadequate Care for Patients with Specialized Needs

Patients with specialized needs are not receiving adequate care at North Carolina's four state-operated psychiatric hospitals. Those patients with specialized needs include patients exhibiting behavioral problems, patients who are dually diagnosed as mentally ill/mentally retarded ("MI/MR"), suicidal patients, patients who require treatment for substance abuse, and patients who are hearing impaired.

a. Patients Exhibiting Behavioral Problems

Behavioral management planning and psychological services are inadequate at North Carolina's four state-operated psychiatric hospitals. Of the records reviewed, we found numerous patients with recurrent behavioral problems, including self-injurious behavior, who were not receiving appropriate behavioral management.

The behavioral plans we reviewed lack basic elements, such as functional analyses that define the frequencies and contingencies associated with target behaviors, and are not integrated with patients' overall plans of care. Treatment goals are vague and fail to provide an objective, measurable basis for evaluating patient progress. To the extent that behavioral programming does exist, the primary emphasis is on containment rather than teaching alternative, adaptive behaviors. The result is that patients with the most severe needs receive inadequate therapeutic care and treatment.

The absence of adequate behavioral programs at the four hospitals has a particularly adverse impact on certain civilly-committed patients with difficult behavioral problems. The State has chosen to manage these patients by placing them in the forensic unit at Dix. These so-called "exception" patients represent approximately 10 percent of the individuals in the forensic unit. They are subjected to measures that pose significant psychological risks, that deviate substantially from

generally accepted professional practices, and that are not applied to civilly-committed patients elsewhere in Dix or the other three hospitals. These measures include locking patients in their rooms upon entry (essentially placing the patients in constant seclusion), and exposing patients to a punitive disciplinary process designed to deal with criminally-charged individuals. The State, of course, is free to impose any reasonable measures that it deems necessary to ensure the safety of patients and staff in the institution. But individualized behavioral programs would allow the State to respond to security concerns while, at the same time, fulfilling its obligation to provide these "exception" patients with a constitutionally acceptable level of therapeutic care.

b. Patients Dually Diagnosed as MI/MR

Each hospital has identified approximately 15-20 patients who are dually diagnosed as MI/MR with specialized treatment and training needs. In accordance with generally accepted professional practice, patients who are dually diagnosed with mental illness and mental retardation need to receive both appropriate individualized treatment to stabilize their psychiatric symptoms and appropriate individualized training to improve adaptive functioning based on their individual needs. These needs, however, are not being met. Treatment teams fail to utilize appropriate psychological evaluations to assess each patient's cognitive deficits and strengths in order to ensure that appropriate treatment and training interventions are selected. Staff at all four hospitals are ill-equipped in terms of resources and training to provide adequate services to this population. No specialized units exist at any of the four hospitals for the care of patients with mental retardation. The failure to provide adequate treatment and training for the patients dually diagnosed as MI/MR represents a significant departure from generally accepted professional practices and standards.

For example, Cherry patient Gordon S.' last psychological testing for treatment planning purposes dates back to 1984. Other patients, including Susan D. and Emily P., both admitted in 2000, have no assessment of their cognitive and intellectual functioning in their respective charts. Our expert found that Cherry patients lack the basic assessments that are necessary for meaningful treatment planning.

At Dix, two patients dually diagnosed as MI/MR, Jacob P. and Jebeziah M., have been housed in the unit designed to serve a

forensic population, due to their behavioral problems. Neither patients receive specialized training or treatment. Rather, both spend most of their time locked in their bedrooms.

The lack of specialized treatment and training is recognized by the facilities themselves. For example, the executive team of Broughton in discussing the approximately 20 clients dually diagnosed as MI/MR at the hospital concluded: "These clients are not getting program needs in this setting and we are not able to get the clients into Western Carolina Center or Black Mountain." (Leadership Group Minutes, March 8, 2002).

c. Suicidal Patients

Patients at risk of suicide receive inadequate care due to inappropriate treatment, inadequate policies, and untrained staff.

Chart review at all four hospitals revealed that many patients suffer from suicidal ideation and, in some instances, have attempted suicide. For example, at Broughton alone, there were at least six serious suicide attempts in the three month period preceding our tour (i.e., December 2001 to March 2002). Three patients had attempted drug overdoses in December that included Ativan, aspirin, and another unknown drug. One patient attempted strangulation and another had self-inflicted lacerations on both wrists with a razor blade. While it is unclear from the records if these persons were able to attempt suicide due to insufficient staffing or untrained staff, it is clear that the policy for supervision of suicidal patients is inadequate.

At all four psychiatric hospitals, our experts found no clear policy regarding suicide assessment and treatment. For example, at Umstead, Broughton, and Cherry, the suicide assessment policy fails to provide specific information or criteria on how to assess suicide risk. At Dix, the policy regarding supervision of suicidal patients does not indicate the level of supervision that should be utilized. Also, the suicide assessment is cursory in that it does not seek sufficient, specific information from patients about suicidal plans, history or thoughts. The lack of a uniform, clear policy, coupled with untrained staff, at the four hospitals places patients at continued risk of failing to be evaluated, treated, and monitored appropriately.

d. Patients Requiring Treatment for Substance Abuse

There is a critical need for specialized treatment for those North Carolina patients who require treatment for substance abuse as well as the underlying mental illness. Substance abuse is a recognized psychiatric disorder. The failure to provide specialized treatment for these dually diagnosed patients is clearly contrary to generally accepted professional practices. If a patient is dually diagnosed with both a severe mental disorder and a severe substance abuse disorder, addressing one and not the other is simply inadequate care. The two disorders become interrelated to the point that stabilizing the mental disorder, and not the substance abuse disorder, often leads to relapse, decompensation, and recidivism.

Chart review by our experts indicated that at Broughton, Dix, and Cherry, the hospitals generally fail to assess, identify or treat these dually diagnosed patients. This is true despite the high percentage of patients being admitted with a history of substance abuse (Broughton – 65 percent, Dix - 55 percent, and Cherry - 55 percent). New patients are not properly screened and assessed for substance abuse problems. As a result, co-existing substance abuse diagnoses are not being identified appropriately at admission.

Moreover, even when substance abuse problems are identified, the three hospitals lack appropriate treatment protocols and provide inadequate treatment. As an example, we note two Dix patients with multiple admissions with a poly-substance abuse diagnosis. One patient, Carol L., had five previous admissions but her treatment plan did not address her poly-substance abuse problem. Another patient, Leslie B., had 30 prior admissions and an extensive history of poly-substance abuse. Her psychiatrist at a treatment team meeting stated that "we are not going to resolve her substance abuse. It's not really a criteria for a patient being here." As a result, her continuing problem with substance abuse is not addressed properly in treatment.

In addition, the data provided at each of the facilities demonstrated a significantly higher rate of recidivism for patients with co-existing substance abuse disorders than for patients exhibiting solely psychiatric disorders. For example, Cherry's data reveals that 70 percent of the patients who are readmitted within thirty days have a co-existing substance abuse disorder. The high percentage indicates that many of the patients with co-existing mental health and substance abuse disorders who are released into the community are not receiving

effective and appropriate treatment. North Carolina's failure to assess, identify, and treat adequately co-existing substance abuse disorders has resulted in patients cycling through repeated discharges and re-admissions.

Of special note is the lack of any standardized mechanism to treat alcohol withdrawal. If not properly treated, alcohol withdrawal is a potentially life-threatening disorder. It is standard practice in the medical community for patients experiencing alcohol withdrawal to be prescribed benzodiazepines as well as thiamin, multi-vitamin or nutritional supplements in order to prevent major complications, including damage to the brain and death. But North Carolina fails to follow any such protocol. The result is that many patients in need of acute alcohol detoxification are placed at risk and some have developed serious complications. For example, at Broughton, two patients, Larry B. and Bernard H., both admitted with alcohol dependency, were not prescribed the appropriate medications and have exhibited memory problems indicative of damage to the brain. Similarly, at Cherry, two patients with a diagnosis of alcohol dependence, Jane R. and Lois M., failed to receive appropriate medication for alcohol withdrawal placing them at risk of brain damage or death.

e. Patients Who Are Hearing Impaired

The Deaf Services Unit at Dix is a statewide unit for individuals who are hearing impaired. The unit has a capacity of 12 patients and at the time of our tour had nine patients. Issues regarding quality of care in this unit generally are similar to those that exist elsewhere in Dix.

From a positive standpoint, our experts identified several promising behavioral plans recently developed on this unit. The plans were specific, individualized and directed toward measurable, targeted behaviors. Because the plans had not yet been implemented, our experts were not able to assess their effectiveness. One concern we have, however, is that patient rooms do not uniformly have a call bell system for patients to contact nursing staff nor do they have visual fire alarms. These failures pose great risk of injury, including death, in the event of an emergency.

3. Inadequate Psychopharmacological Practices

a. Inappropriate Medication Practices

Medication practices at the four hospitals represent a

substantial departure from generally accepted professional practice.

Generally accepted professional practice requires the development and implementation of a pharmacological component of a treatment plan that reflects the exercise of professional judgment for medication treatment including: diagnosis, target symptoms, risks and benefits of particular medications, and consideration of alternate treatments. Based on these factors, the rationale for each patient's course of treatment should be included in the physician's progress notes. Psychotropic medications should be used as an integral part of a treatment program to manage specific behaviors in the least restrictive manner, to eliminate targeted behaviors/symptoms, and to treat specific psychiatric disorders. Psychiatric medications should be integrated with any behavioral intervention plan. Pharmacologic treatment should be carefully monitored and tracked with each medication change, as well as the rationale for the change, documented in a physician's order. All lengthy administrations of medication should be periodically evaluated to assess their efficacy.

In general, these practices are not followed at any of North Carolina's hospitals. Psychotropic medications regularly are administered without adequate documentation regarding the rationale for each patient's course of treatment, an indication as to the symptoms targeted, or a mechanism to track the efficacy of the medication. These omissions often result in unnecessary administration of medications that have not proven to be effective. At each facility, we found individuals who have received psychotropics for years without any clinically significant improvement. The result is patients who are needlessly administered psychotropic medications that do not improve their conditions and expose them unnecessarily to side effects and other risks.

The following paragraphs identify examples of inappropriate medication practices at the individual hospitals:

i. Umstead Hospital

Umstead does not have a hospital-wide program for the assessment of psychotropic medication usage. Many records do not explain adequately why patients are receiving psychotropic medications. For example, the lack of documentation in Andrew P.'s chart made it impossible to assess the effectiveness or appropriateness of his peculiar pharmacological treatment. Andrew P. was given an unusual combination of two atypical

antipsychotic medications (Seroquel and Zyprexa) and a typical antipsychotic medication (Moban). Despite this unorthodox medication regimen, there is not a comprehensive explanation in the record stating why such an uncommon combination of medications is appropriate.

Umstead's own internal psychotropic medication audit during the year 2000 found that polypharmacy was common in patients with borderline personality disorder, and that justifications for the use of psychotropic medication were noted in only 57 percent of the records. The audit drew no conclusions, except that medications were being inappropriately used. The hospital's corrective action was to develop a form for recording medications, and to simply "encourage physicians" to change their practice. Umstead, however, has no way to track whether this has occurred and, in fact, has not re-examined the issue.

ii. Broughton Hospital

Broughton has a very impressive pharmacy and an excellent pharmacy staff. The hospital, however, has failed to use its pharmacy program to provide adequate medication procedures. The medical staff has not adopted specific protocols for particular medical conditions or for medication utilization. The result is a lack of uniform standards of practice hospital-wide with some patients not receiving appropriate medication. For example, Carol B. has a primary diagnosis of bipolar affective disorder. A review of the patient's record reveals that her primary diagnosis apparently was not addressed, and she seems to have received no medication necessary to treat her disorder.

iii. Dix Hospital

Dix should be commended for its exemplary Clinical Research Unit. The independent unit is utilizing 13 very good protocols that include the study of various atypical antipsychotic medications. These programs are highly organized, discrete psychopharmacological interventions that are connected with outcome measures to determine what, if any, benefit a particular intervention has for a particular patient. The unit serves as a model to be emulated throughout not only the hospital, but statewide.

However, Dix needs to improve the manner in which it monitors and dispenses psychotropic medications in its other units. For example, Gail G. is on a complicated medication regimen that includes a high dosage of Seroquel, a psychotropic medication. Yet, the patient's record fails to justify the high

dosage nor is there any discussion of the use of alternate atypical medications.

iv. Cherry Hospital

Cherry has not adopted any specific protocols with regard to the use of psychotropic medications. As a consequence, Cherry's medication practices are inconsistent. For example, Michael H.'s record did not justify or explain the choice of medication, the dosage level, or whether an alternative treatment that may be more effective had been considered. The patient's treatment plan indicates "the patient's persistently psychotic state has not improved."

As another example, Neal B. was admitted with several diagnoses including personality disorder, coronary artery disease, and alcohol dependency. He was given a relatively new medication approved only for the treatment of sleepiness due to narcolepsy or sleep apnea. There was no evidence in the record that the patient had this disorder, and the record failed to explain or justify this choice of medication.

b. Inappropriate Use of PRN's/Chemical Restraint

North Carolina's lack of appropriate psycho-pharmacological practices has led to inappropriate PRN (pro re nata or "as needed") medication use. All four hospitals frequently administer PRN medication that is not targeted to specific symptoms of mental illness. The most common drug used appears to be benzodiazepines (medication prescribed to alleviate anxiety and panic disorders, but also commonly used as a sedative or muscle relaxant). Nearly half of North Carolina patients have either a regular or PRN order for a benzodiazepine, and in some cases multiple sedating and habituating agents. The use of benzodiazepines should be carefully scrutinized due to this population's increased sensitivity to drug side-effects. Benzodiazepines impair thinking and cognition, especially in elderly patients, and may predispose patients to falls that, in turn, result in injuries. The records we reviewed lacked any justification for this potentially dangerous drug practice. Rather than prescribing antipsychotic medications and benzodiazepines for their specific indication as agents that target symptoms of psychosis and anxiety, it appears that clinicians prescribe these medications for their secondary sedating effects and as a substitution for appropriate therapeutic interventions. This practice constitutes chemical restraint, which is in violation of federal regulations, see

42 C.F.R. § 482.13, and does not conform to generally accepted professional standards.

The problem of inappropriate PRN orders is exacerbated by staffing shortages. Because there is a shortage of registered nurses at North Carolina's psychiatric hospitals, standing PRN orders for benzodiazepines and antipsychotic medications result in relatively untrained staff making daily decisions about medications.

c. Forced Intramuscular Medication

Chart review indicates that staff at Broughton, Cherry, and Dix Hospitals forcefully administer intramuscular medications when patients refuse oral medication. This policy is intended to coerce patients into taking oral medication they do not wish to ingest. The use of forced intramuscular medication when a patient refuses oral medication is completely contrary to accepted professional practices, violates patients' federal constitutional rights, and can lead to serious medical consequences.

In some cases, the intramuscular medication injections the patients receive are different than the medications they refuse. This is dangerous because the medical needs of the patient are not being met; instead medication is being used as punishment and patients are being exposed to the side-effects of a painful intramuscular medication injection. Moreover, in some instances, the forced intramuscular medication is not an adequate replacement for the refused medication.

For example, at Broughton, Ralph E. has standing orders for intramuscular medications (Haldol and Ativan) as a replacement for each refused oral anti-convulsant medication. The intramuscular injections are thus different from the medications being refused. Similarly, at Cherry, Helen D. was forcefully injected with Thorazine up to three times daily for refusal of her prescribed oral medication, Seroquel. Such large injections of Thorazine are painful, have potentially serious side-effects (including respiratory failure) and are not an appropriate substitute for the prescribed medication. Meanwhile, at Dix, whenever Kevin C. refuses an oral dose of his prescribed medication, Depakote, he is forcefully injected with Thorazine. Thorazine and Depakote are different classes of psychotropic medicine used to treat dissimilar conditions.

d. Inadequate Integration of Pharmacological Interventions within Treatment Plans

All of the hospitals failed to integrate adequately the overall management of patient care. Pharmacological interventions in particular need to be better integrated into treatment plans. As noted above, records at all four hospitals lack clear outcome criteria that were specifically measurable or tied to particular medication interventions. As a result, clinicians are unable to adequately evaluate treatment outcomes. These failures have contributed to subjecting patients to treatment that often is ineffective, resulting in behavioral problems and psychiatric disorders that are unimproved.

We found numerous examples where pharmacological interventions were not adequately integrated into treatment plans and clinicians failed to take into account the overall management of patient care. Examples at Dix include Doris S. (pre-existing obesity and possible hypertension not considered); Paul B. (poor glucose control, no discussion of alternative atypical anti-psychotics that might have less of a metabolic effect); and Scott S. (contraindicated stimulant administered without an explanation). Examples at Broughton include James L. (Clozaril, a medication that frequently causes severe constipation, continued even after patient developed a small bowel obstruction); and Bernard H. (erratic management of acute detoxification). Examples at Cherry include Brian N. (complicated regimen of medication that may be contraindicated); and Dennis B. (medication given that did not take into account patient's metabolic disfunction). Examples at Umstead include Lucy S. (patient not given supplemental thyroid medication despite elevated lab results); Wayne T. (medication did not take into account patient's Tourette's); and Jeffrey L. (continued use of electro-convulsive therapy ("ECT") in a patient diagnosed with dementia).

Staff at the four hospitals acknowledged to our experts the need to integrate adequately pharmacological interventions within treatment plans.

B. Inappropriate Use of Restraints and Seclusion

Restraint and seclusion policies and practices depart substantially from generally accepted professional standards throughout all four hospitals. Restraint and seclusion are emergency interventions to be used only when other interventions fail to prevent imminent danger to self or others. All four

hospitals fail to develop and implement policies and procedures to appropriately limit the use of restraint and seclusion to emergency situations.

Documentation and analysis of restraint and seclusion is particularly deficient. At all four hospitals, rarely is adequate justification documented for restraint and seclusion orders. Staff often fail to identify the factors precipitating restraint and seclusion, and lack an understanding of less restrictive measures that could be utilized to handle patients' behaviors. As a result, patients are placed inappropriately in restraint and seclusion when alternative, less intrusive interventions are available. Patient records uniformly revealed a lack of objective, recorded criteria for a patient's release from restraints or seclusion. The lack of criteria results in patients remaining in restraints and seclusion long past the point, according to accepted professional practice, when release should occur. In addition, critical, post-episode debriefing information analyzing the use of restraints and seclusion either is omitted or terse, vague and generalized. This, in turn, has led to the overuse of restraint and seclusion because the hospitals are not analyzing incidents to determine what, if anything, can be done differently.

Examples of deficient documentation (and thus potentially inappropriate use) of restraint and seclusion include: Dix patient James P. (placed in four-point restraints for over two hours despite the fact that, according to a notation in the record, he was calm the entire time); Umstead patient Kelly S. (documentation of three restraint episodes over the course of four days in January 2002 indicated that precipitating factors were identified, but none were listed in the record); Umstead patient Douglas L. (rationale listed for restraints on February 16, 2002, was merely "safety").

We are particularly concerned about the use of restraints and seclusion for children and adolescents. We found numerous examples where restrictive measures were being utilized inappropriately. For example, John M., a patient on Umstead's children's unit, had 16 restraint and seclusion episodes in less than one month, with vague release criteria, often no post-incident debriefing information, and no analysis of precipitating factors that might facilitate a more proactive treatment approach. Dix's 17-year-old Kimberly C. and 12-year-old Gus R., meanwhile, were repeatedly placed into seclusion for not following staff instructions.

There also is an indication that medical/surgical restraints are being used inappropriately on geriatric wards as a way to address ambulation and gait issues. For example, Umstead patient Ralph R. was restrained by being strapped to a geri chair around-the-clock for six days, except for required two hour breaks, even though when observed he had no difficulty walking. Mr. R.'s chart revealed no assessment or evaluation as to the continued need, or justification, for the use of these restraints.

The restraint and seclusion policies at each of the four hospitals need to be updated and then implemented to conform with generally accepted professional standards and, in particular, need to include appropriate definitions of mechanical as well as chemical restraints.

C. Inadequate Nursing and Medical Care

It is standard professional practice for psychiatric hospitals to establish uniform policies, procedures, and protocols to ensure the consistent provision of adequate medical care and treatment. Such policies and procedures should assist in defining the problem to be treated, guide in assessing the patient, set forth necessary steps if the condition does not improve with medication or treatment given, and identify trigger points for physician notification and intervention.

It also is standard practice in psychiatric hospitals to have a Pharmacy and Therapeutics ("P&T") Committee which, among other responsibilities, provides leadership on drug prescriptions at the facility, examines the rationale for the use of polypharmacy, checks on medication errors, and provides information on drug development. Finally, it is a standard professional practice to maintain a formal peer review system as a quality assurance tool and a means to ensure the provision of consistent medical care.

The absence of the foregoing components of adequate medical oversight in all four hospitals is, although perhaps not necessarily a violation of federal law in each instance, contrary to the increasingly common and generally accepted professional practices, thus potentially jeopardizing the care and treatment of North Carolina's patients. For example, North Carolina does not have any standard of care protocols to direct nursing practices and standardize nursing care at any of the four psychiatric hospitals. The lack of appropriate protocols does not comport with generally accepted professional practice and presents an unreasonable risk to the health and safety of patients. For example, at Dix, the lack of a protocol and the

resulting failure of the nursing staff to contact the physician when a patient's blood pressure significantly changed may have contributed to the death of a geriatric patient. Our review of peer review reports revealed that neither evening nor night shift nurses called the physician on-call due to the lack of a protocol even though the patient's condition rapidly deteriorated after hours.

Moreover, lack of staffing contributes to the lack of adequate treatment, delaying prompt and adequate evaluation and precluding the delivery of necessary care. The most critical shortage in all four hospitals is in direct care nursing. Inadequate nursing coverage has resulted in a lack of monitoring, review, and coordination of medical services. There also is an insufficient number of nursing staff to implement behavior plans or provide other treatment. At times, treatment groups are cancelled due to the lack of staff. As discussed above, in the absence of consistent structured programming and treatment, staff rely upon the inappropriate use of sedating medications, and restraint and seclusion to manage behavioral episodes.

D. Failure to Protect From Harm Due To Inadequate Quality Assurance and Performance Improvement

North Carolina's four facilities place patients at continued risk of harm because they do not implement appropriate quality assurance and performance improvement activities. As a result, the four hospitals often do not identify or analyze deficiencies in the treatment and services provided to patients or in the systems and procedures designed to protect patients from harm in a timely or adequate manner.

North Carolina's quality assurance and performance improvement programs often are poorly organized and fail to establish priorities to identify the particular issues that need to be addressed. The hospitals do not establish criteria for analyzing the variety of data that they routinely collect, and fail to analyze appropriately the data for trends and underlying causes.

North Carolina's facilities also lack adequate procedures for investigating untoward events and serious injuries. Our consultants found that staff conduct little or no follow-up to determine the cause of an incident, its effect on the patient, or how similar incidents might be avoided in the future. Moreover, a review of records revealed that all of the four facilities fail to conduct adequate mortality reviews to ascertain the root causes for all unexpected deaths.

E. Unsafe and Inadequate Physical Plant Conditions

1. Umstead Hospital

Umstead's physical plant presents significant challenges to the hospital's operations in terms of sustaining a unified and efficient treatment program and providing accessible and safe areas for treatment, recreation, and housing. There are, for example, suicide hazards in almost every bedroom and bathroom such as grab bars, protruding showerheads, and door knobs that could be used by a patient to hang himself. To be sure, the facility has modified the grab bars in one of the bathrooms on the admitting unit. Such modifications, however, are necessary throughout the facility in rooms housing patients who might pose suicide risks.

The housing of the geropsychiatry unit on the second floor of the facility poses another serious, potentially life-threatening hazard. The hospital does not have an appropriate fire escape plan. In the event of a fire, these patients, who are generally non-ambulatory and often confined to wheelchairs, could not be evacuated quickly and safely from the second floor.

In addition, we found that wheelchairs were not being maintained so that patients could safely use them. Wheelchairs were in severe disrepair - broken foot drops, torn cushions, and improper fittings. In fact, according to a supervisor's report dated February 12, 2002, all of the wheel chairs on the adult admissions unit were broken and needed to be repaired. The situation is defined as the facility facing a "wheelchair crisis state." At the time of our tour, the hospital had entered into a contract with a vendor to repair all of the wheelchairs.

2. Broughton Hospital

Broughton is generally a well-preserved, clean, spacious facility. The facility recently has been reviewing its suicide risks and has made some improvements, specifically in eliminating long cords and replacing shower rods, both of which could be used for hanging. The facility, however, still has numerous suicide risks in bedrooms and bathrooms such as grab bars, protruding showerheads, and doorknobs. Moreover, at least six patients obtained hazardous substances from within the facility and have used these substances to attempt suicide between December 1, 2001, and March 19, 2002. The availability of these substances raises concerns regarding the environment as well as staff supervision of patients.

3. Dix Hospital

The physical environment at Dix presents serious safety issues. Like the other facilities, there are numerous suicide risks in bedrooms and bathrooms such as grab bars, hand held or protruding shower heads, and door knobs.

4. Cherry Hospital

Cherry's physical plant is generally well maintained. Like the other facilities, however, there are numerous suicide risks in bedrooms and bathrooms such as grab bars, hand held or protruding shower heads, and door knobs. Moreover, the hospital's practice of blocking out the windows with pictures or paper on the doors to patient bedrooms is unsafe as this does not allow staff to observe patients.

F. Inadequate Discharge Planning and Failure to Provide Services in the Most Integrated Setting

North Carolina's discharge planning practices are inadequate and consistently violate both the Americans with Disabilities Act and generally accepted professional standards of care. The State also fails to ensure that services are provided to qualified individuals with disabilities in the most integrated setting appropriate to their needs.

Generally accepted professional standards require that discharge planning be a comprehensive process that begins at the time of admission, identifies and addresses the psycho-social needs of the patient, continues throughout the course of in-patient treatment, and includes appropriate community linkage and follow-up supports and services in order to provide the necessary continuity of care. During the assessment and treatment planning phases, discharge criteria should be established, included in the master treatment plan, and regularly reviewed by the treatment team. The patient's progress toward meeting discharge criteria and any barriers to discharge should be monitored in treatment plan updates (the treatment team reviews) and progress notes. Treatment should be directed toward helping the patient achieve the level of functioning necessary to be ready for discharge. As part of the development of the initial and individualized comprehensive treatment plan, the interdisciplinary treatment team should assess each patient at appropriate clinical intervals to evaluate whether the hospital is the most appropriate setting to meet the clinical needs of the patient.

In order for the hospital to appropriately link patients to community supports and services, the State must ensure the presence of adequate community supports and services needed for each individual, when the individual does not oppose such treatment and the placement can be reasonably accommodated. This duty is consistent with the State's obligations pursuant to the ADA to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

During our investigation of North Carolina's psychiatric hospitals, our experts focused on the various elements of discharge and aftercare planning. During this review, we found consistent failings by the hospitals in the area of discharge planning. At each of the hospitals, chart review revealed that patients' progress toward meeting discharge criteria and any barriers to discharge are typically not monitored. As a result, treatment is often not integrated and directed toward patient discharge. In addition, at each of the four psychiatric hospitals, treatment teams generally fail to assess adequately each patient at appropriate clinical intervals to evaluate whether the hospital is the most appropriate setting to meet the clinical needs of the patient. Finally, after-care discharge plans do not adequately address the needs of the patient, nor does the State provide appropriate community-based treatment for persons with mental disabilities when the State's treatment professionals determined that such placement is appropriate.

1. Umstead Hospital

At Umstead Hospital, discharge plans and other discharge-related documentation are vague and do not address adequately the needs of the patient.

For example, Gary R., a three-time patient with an extensive substance abuse history, was discharged to a homeless shelter after each hospital stay between November 2001 and February 2002. None of his discharge or aftercare plans addressed his substance abuse problem. Nor did the State provide adequate community support services to address the substance abuse problems, thereby likely contributing to his recurrent psychotic episodes and re-admissions.

Thomas W., another Umstead patient, was discharged with critically-needed elements of his aftercare plan left blank or unaddressed, including a serious medical condition (an alcohol-induced ulcer).

Douglas L. was hospitalized after a psychotic episode during which he assaulted his wife. Despite this history, Mr. L. was discharged back to his family without sufficient evidence that his dangerousness had been addressed adequately or that treatment focusing on appropriate alternative behaviors had been addressed while hospitalized or arranged thereafter.

In addition, interviews with staff regarding discharge planning activities, available community resources, and the relationship between hospital staff and community liaisons yielded inconsistent responses. Some staff members reported the lack of Area Program community liaisons while others reported that the community liaisons assist with identifying community resources. One staff member acknowledged "not knowing much about community mental health." The lack of knowledge and inconsistency among staff members negatively impacts the discharge planning process, often resulting in a failure to utilize available resources in the community.

2. Broughton Hospital

Discharge planning is not being provided in a comprehensive manner at Broughton Hospital. Chart review reflects the deficiencies previously noted with respect to the development of comprehensive assessments and treatment planning. In addition, patients are not being assessed at appropriate clinical intervals to evaluate whether the hospital is the most appropriate setting to meet their clinical needs. Finally, after-care discharge plans are perfunctory and do not address adequately the needs of the patient.

Chart review for Calvin M., who has a history of 15 re-admissions and diagnoses of paranoid schizophrenia and substance abuse, indicated no changes or modifications of his treatment plan during any of his hospitalizations. His chart reveals a lack of after-care discharge plans to address adequately his individualized needs.

Richard A. was diagnosed with acute mania, poly-substance abuse, suicidal ideation, depression, self injurious behavior, and a history of having a sexual relationship with his biological mother. His treatment plan was to "manage self-destructive feelings; absence of suicidal ideation; and demonstrates willingness to participate in aftercare plan." The treatment plan was neither measurable nor objective. There is no indication of how his needs were being addressed nor of his progress towards discharge. He was subsequently discharged back to his mother -- with whom he had a documented sexual

relationship -- without an appropriate aftercare plan to address the factors that led to his hospitalization.

Robert P., another Broughton patient, with a history of an eating disorder, remained hospitalized at the time of our review despite the fact that the treatment team and Area Program agree that he no longer requires acute in-patient treatment.

In addition, as in Umstead, the lack of staff knowledge and the inadequate relationship between hospital staff and community liaisons often resulted in a failure to appropriately use available resources in the community. Hospital social workers report that it is often difficult to arrange aftercare appointments for patients and that patients frequently must wait three to four weeks after their discharge for an appointment with a psychiatrist. As a result, some patients become ill and non-compliant before their first aftercare appointment and have to be re-hospitalized.

3. Dix Hospital

As with the other hospitals, discharge planning is not an integral part of the treatment planning process at Dix Hospital.

Carol L., for example, was admitted on January 7, 2002, with diagnoses of poly-substance dependence and borderline personality disorder with antisocial traits. This was her fifth admission over a 45-day period since November 28, 2001. Her aftercare plan for each admission was essentially identical, and none addressed the treatment issues that led to the prior re-admissions. Moreover, although homeless, the most recent aftercare plan indicated that Carol L. is being discharged "home." Given, however, that the address listed is that of a shelter, the State failed to provide for the most integrated setting appropriate to meet Carol L.'s needs.

Lois B. was admitted to Dix with diagnoses of borderline personality disorder and poly-substance abuse. This was her thirtieth admission. Although the patient has an extensive history of alcohol and cocaine abuse, her psychiatrist stated at a treatment team meeting that "we are not going to resolve substance abuse, it's not really a criteria for patient being here. Substance abuse shouldn't have been put on as a reason for admission." As a result, contrary to generally accepted professional practice, the substance abuse problem was not factored into the treatment planning, and consequently was not a part of the discharge or aftercare planning.

4. Cherry Hospital

Based on a review of patient records and staff interviews at Cherry Hospital, we found discharge planning and the aftercare plans to be perfunctory and inadequate. The plans lacked any clearly defined discharge criteria. Psycho-social factors that had been documented as contributing to an exacerbation of symptoms prior to admission are not consistently factored into the discharge planning process. For example, Roger P. was admitted after a drug relapse with suicidal behavior. On his prior admission, he had been discharged to another patient's apartment who had been discharged from Cherry. The other patient, who also had a substance abuse problem, was reportedly drinking and using drugs. Roger P. relapsed. Roger P.'s chart, during his recent re-admission, reveals the patient's desire for a long term substance abuse program. His aftercare plan, however, does not address his substance abuse problems. The plan merely states that "the patient is to be discharged to self."

III. MINIMUM REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional and federal statutory rights of residents at Dix, Broughton, Cherry, and Umstead Hospitals, North Carolina should implement the minimum remedial measures set forth below. These apply to all four facilities unless otherwise indicated.

A. Mental Health Care

1. Assessments and Treatment Planning

a. Provide adequate and appropriate psychiatric and other mental health services, including adequate psychological services and behavioral management, in accordance with generally accepted professional standards. Behavioral management should focus on teaching alternative, adaptive behaviors.

b. Conduct interdisciplinary assessments of patients consistent with generally accepted professional standards. Expressly identify and prioritize each patient's individual mental health problems and needs, including maladaptive behaviors and substance abuse problems.

c. Reform the treatment process so that patient treatment is appropriate, individualized, coordinated, and properly managed. In addition, staff should be trained to write professionally appropriate behavioral goals and objectives, and include, when possible, patient and family input. Appropriate individualized treatment plans should be implemented in a consistent manner in accordance with generally accepted professional practices. The treatment process should provide each patient a reasonable opportunity to function as independently and effectively as possible. To that end, (i) treatment planning should reflect an interdisciplinary process based on reliable objective data and clearly established measurable goals, and (ii) treatment plans should be consistently assessed for their efficacy and reviewed and revised when appropriate.

2. <u>Care for Patients with Specialized Needs</u>

a. Develop and implement psychological evaluations to assess each patient's cognitive deficits and strengths to ensure that treatment interventions are selected based on the patient's capacity to benefit.

b. Provide adequate psychological services and behavioral management in accordance with generally accepted professional standards. Ensure that behavioral management emphasizes teaching alternative, adaptive behaviors as well as therapeutic care, treatment, and programming.

c. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.

d. Develop and implement policies to ensure that patients with special needs (patients who are dually diagnosed as mentally ill/mentally retarded), patients at risk of suicide and self-injurious behavior, and patients who require treatment for substance abuse) are

appropriately evaluated, treated, and monitored in accordance with generally accepted professional standards.

e. For patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.

f. Ensure a sufficient number of qualified staff to supervise suicidal patients adequately and ensure that physician orders for enhanced supervision be communicated to appropriate staff and implemented.

g. For patients requiring treatment for substance abuse, develop and implement treatment plans, including aftercare post-institutional plans that (i) ensure treatment addresses co-morbidity, (ii) ensure treatment is based on the individual needs of the patient, and (iii) reflect the need for aftercare services if appropriate.

h. Ensure that staff receive adequate training to serve the needs of patients requiring specialized care.

i. For those patients identified as hearing impaired, place call bell systems and visual fire alarms in all appropriate rooms.

3. <u>Psychopharmacological Practices</u>

a. Ensure that pharmacological and psychopharmacological practices comport with generally accepted professional standards. Ensure that the use of all drugs be professionally justified, carefully monitored, documented, and reviewed by qualified staff. Ensure that medications be prescribed based on clinical need.

b. Revise psychopharmacological practices to ensure that the use of antipsychotics, medication combinations, PRN orders and the prescription of benzodiazepines, comport with generally accepted professional practice.

c. Ensure that the use of PRN medications for behavior control comport with generally accepted professional standards.

d. Ensure that staff are adequately trained and knowledgeable about the risks and side effects in administering benzodiazepines and or/antipsychotic medications.

e. Ensure that patient records identify the behavioral problem and justification for the use of any antipsychotic medication or benzodiazepines.

f. Ensure that the decision to administer an intramuscular medication is employed pursuant to the exercise of professional judgment by a qualified professional. Also, ensure the patient's record clearly documents the behavioral issue(s) and justification for use of the intramuscular medication. Develop and implement a policy to eliminate the use of forced intramuscular medication that differs from the patient's prescribed oral medication.

g. Develop and implement an integrated behavioral and psychopharmacological treatment plan based on combined assessment and case formulation.

h. Ensure that treatment team members communicate and collaborate effectively to provide patients with the most effective treatment in keeping with generally accepted professional standards.

B. <u>Restraints and Seclusion</u>

Absent exigent circumstances -- *i.e.*, when a patient poses an imminent risk of injury to himself or a third party -- any devise or procedure that restricts, limits or directs a person's freedom of movement (including, but not limited to, chemical restraints, mechanical restraints, physical/manual restraints, or time out procedures) should be used only after other less restrictive alternatives have been assessed and exhausted. More specifically, the facilities should:

1. Develop and implement a policy on restraint and seclusion measures that comports with generally accepted professional standards.

2. Ensure that the decision to restrain and/or seclude a patient only be employed pursuant to the exercise of professional judgment by a qualified professional. Eliminate the practice of using restraints or seclusion for the convenience of staff, or in lieu of treatment.

3. Ensure that patients in restraints and/or seclusion be adequately and appropriately monitored. Also, ensure that the use of restraints and seclusion be properly documented and reviewed in a timely fashion by qualified staff.

4. Ensure that the criteria for release from restraints and seclusion are clearly identified and written in the patient's treatment plan.

C. <u>Nursing and Medical Care</u>

Individuals with health problems should be promptly identified, assessed, diagnosed, treated, and monitored consistent with current professional standards of care. Staff should complete appropriate documentation adequate to withstand clinical scrutiny. More specifically, the facilities should:

1. Hire and deploy a sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients with adequate supervision and medical and mental health treatment.

2. Ensure that patients receive adequate medical, including emergency, care in accordance with generally accepted professional standards of care.

3. Ensure adequate and appropriate interdisciplinary communication among relevant professionals. Ensure that physicians write concise and complete orders pursuant to generally accepted professional standards.

4. Develop and implement nursing protocols for medical care and treatment.

D. <u>Quality Assurance and Performance Improvement</u>

1. Develop and implement an adequate quality assurance process in accordance with generally accepted professional standards that at a minimum:

   a. actively collects data relating to the quality of nursing and medical services;

   b. assesses these data for trends;

   c. initiates inquiries regarding problematic trends and possible deficiencies;

   d. identifies corrective action; and

   e. monitors to ensure that appropriate remedies are achieved.

2. Develop and implement adequate procedures for investigating untoward events, serious injuries, and sentinel events.

3. Develop and implement adequate procedures for routinely reviewing incident reports to assess whether individual or systemic trends or issues exist and changes in treatment are warranted.

4. Conduct adequate mortality reviews to ascertain the root causes for all unexpected deaths.

E. <u>Physical Plant</u>

1. Eliminate all suicide hazards in patient bedrooms and bathrooms.

2. Develop and implement adequate nursing protocols to ensure that patients are appropriately supervised and monitored.

3. Develop appropriate evacuation plans.

F. <u>Discharge Planning and Providing Services in the Most Integrated Setting</u>

1. Every resident should be professionally assessed initially upon admission and on a periodic basis

to determine whether continued residential confinement constitutes the most integrated setting appropriate to meet the individual's needs. Specifically, the facilities should:

a. Develop and implement adequate discharge plans that identify the necessary aftercare services to meet the needs of patients upon discharge in accordance with generally accepted professional standards of care.

b. If it is determined that a more integrated setting would appropriately meet the individual's needs, promptly develop and implement, with appropriate consent, a transition plan that specifies actions necessary to ensure a safe, successful transition from each facility to a more integrated setting, the names and positions of those responsible for these actions, and corresponding time frames.

c. Develop and implement a quality assurance/improvement system to oversee the discharge process and aftercare services. This system should ensure that professional judgments about the most integrated setting appropriate to meet each patient's needs are implemented and that appropriate aftercare services are provided that meet the needs of the patient in the community.

2. The State should ensure that it provides community-based treatment for persons with disabilities consistent with federal law.

* * *

The collaborative approach that the parties have taken thus far has been productive, as Dix, Broughton, Cherry, and Umstead Hospitals have exhibited improvements since our investigation began. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding these facilities.

We will forward our expert consultants' reports under separate cover. Although their reports are their work and do not necessarily represent the official conclusions of the Department

of Justice, their observations, analyses, and recommendations provide further elaboration of the relevant concerns, and offer technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in promoting a dialogue aimed at quickly addressing the areas requiring attention.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that the Attorney General may initiate a lawsuit pursuant to CRIPA, to correct deficiencies or to otherwise protect the rights of residents at Dix, Broughton, Cherry, and Umstead Hospitals, 49 days after receipt of this letter. 42 U.S.C. § 1997b(a)(1).

Accordingly, we will soon contact State officials to discuss in more detail the measures that the State must take to address the deficiencies identified herein.

Sincerely,

R. Alexander Acosta
Assistant Attorney General

cc: The Honorable Roy Cooper
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