



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

JAN 9 2008

The Honorable Theodore R. Kulongoski
Governor of Oregon
160 State Capitol
900 Court Street
Salem, OR 97301-4047

Re: CRIPA Investigation of the Oregon State Hospital,
Salem and Portland, Oregon

Dear Governor Kulongoski:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the Salem and Portland campuses of the Oregon State Hospital (OSH). On June 14, 2006, we notified you that we were initiating an investigation of conditions and practices at OSH, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern and practice of conduct that violates the constitutional or federal statutory rights of patients with mental illness who are treated in public institutions.

As part of our investigation, on November 13 through 16, 2006, we conducted an on-site review of care and treatment at both OSH campuses with expert consultants in the fields of psychiatry, psychology, psychiatric nursing, protection from harm, life safety, and discharge planning and community placement. While on-site, we interviewed administrative staff, mental health care providers, and patients, and examined the physical living conditions at the facility. Additionally, before, during, and after our on-site inspection, we reviewed a wide variety of documents, including policies and procedures, incident reports, and medical and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tour with an extensive debriefing at which our consultants conveyed their initial impressions and concerns to counsel, OSH administrators and staff, and state officials.

We appreciate the full cooperation we received from the Oregon Department of Health and Human Services and the Oregon Attorney General's office. We also wish to thank the administration and staff at OSH for their professional conduct, their timely responses to our information requests, and the extensive assistance they provided during our tour. Further, we wish to especially thank those individual OSH staff members, both new and longstanding, who make daily efforts to provide appropriate care and treatment, and who improve the lives of patients at OSH. Those efforts were noted and appreciated by the Department of Justice and our expert consultants. We hope to continue to work cooperatively with OSH and the State of Oregon to address the deficiencies at the Salem and Portland campuses.

In accordance with statutory requirements, I now write to advise you formally of the findings of our investigation, the facts supporting them, and the minimal remedial steps that are necessary to remedy the deficiencies set forth below. 42 U.S.C. § 1997b(a). Specifically, we have concluded that numerous conditions and practices at OSH violate the constitutional and statutory rights of its residents. In particular, we find that OSH: (1) fails to adequately protect its patients from harm; (2) fails to provide appropriate psychiatric and psychological care and treatment; (3) fails to use seclusion and restraints in a manner consistent with generally accepted professional standards; (4) fails to provide adequate nursing care; and (5) fails to provide discharge planning and to ensure placement in the most integrated setting. See Youngberg v. Romeo, 457 U.S. 307 (1982); Title XIX of the Social Security Act, 42 U.S.C. § 1396; 42 C.F.R. Part 483, Subpart I (Medicaid Program Provisions); Americans with Disabilities Act (ADA), 42 U.S.C. § 12132 et seq.; 28 C.F.R. § 35.130(d); see also Olmstead v. L.C., 527 U.S. 581 (1999).

I. BACKGROUND

OSH is the State's primary psychiatric facility for adults, including those over age 65. It consists of two campuses, a 627-bed facility in Salem, where most patients reside, and a 54-bed facility in Portland, which is used for psychiatric rehabilitation services. The Salem facility opened its doors well over a century ago, and some of the original buildings are still in use. In 1988, and again in 2005, state-commissioned reports described various health and safety dangers stemming from the facility's antiquated physical structure and recommended demolition.

Psychiatric services at OSH are provided through two separate treatment programs -- forensic psychiatric services (FPS) and psychiatric recovery services (PRS). FPS consists of 334 budgeted hospital-level beds on ten units and 100 budgeted residential-level beds on three units. This program houses three categories of patients: (1) individuals who have been committed to OSH pursuant to criminal court proceedings (e.g., incompetent to stand trial and not guilty by reason of insanity); (2) inmates transferred from correctional facilities for psychiatric treatment; and (3) individuals who are committed by the courts for a psychiatric and/or psychological evaluation. All FPS patients reside on the Salem campus.

Non-forensic patients receive services through PRS, which consists of 193 budgeted hospital-level beds in Salem and 54 budgeted hospital-level beds in Portland. Five units serve adult patients civilly committed to the hospital due to serious and persistent mental illness, two units serve geriatric patients, one unit serves patients with brain damage, and one unit serves as a medical unit for patients with physical illness or other medical needs.

II. FINDINGS

At issue is whether the State is providing patients at OSH with care and treatment in accordance with its constitutional and federal statutory obligations. Residents of state-operated facilities have a right to live in reasonable safety and to receive adequate health care, along with rehabilitation, to ensure their safety and freedom from unreasonable restraint, prevent regression, and facilitate their ability to exercise their liberty interests. See Youngberg, 457 U.S. at 315, 322. Federal statutes provide similar protections. 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).

More particularly, a state mental health hospital is constitutionally required to provide reasonable, adequate mental health treatment. See Or. Advocacy Ctr. v. Mink, 322 F.3d 1101, 1121 (9th Cir. 2003) (even incapacitated criminal defendants have a liberty interest in restorative treatment); Sharp v. Weston, 233 F.3d 1166, 1172 (9th Cir. 2000) ("[T]he Fourteenth Amendment Due Process Clause requires states to provide civilly committed persons with access to mental health treatment that gives them a realistic opportunity to be cured and released."); Ohlinger v. Watson, 652 F.2d 775, 778 (9th Cir. 1980) ("Adequate and effective treatment is constitutionally required because, absent

treatment, appellants [who were committed as sex offenders] could be held indefinitely as a result of their mental illness."). Treatment is not adequate if it substantially departs from accepted professional judgment, practice, or standards. Youngberg, 457 U.S. at 320-23; Rohde v. Rowland, 898 F.2d 156, 160 (9th Cir. 1990); see also Or. Advocacy Ctr., 322 F.3d at 1120-21.

Patients' constitutional liberty interests in security compel states to provide reasonable protection from harm in mental health hospitals. Youngberg, 457 U.S. at 315-16. States also are compelled by the Constitution to ensure that patients are free from hazardous drugs which are "not shown to be necessary, used in excessive dosages, or used in the absence of appropriate monitoring for adverse effects." Thomas S. v. Flaherty, 699 F. Supp. 1178, 1200 (W.D.N.C. 1988), aff'd, 902 F.2d 250 (4th Cir. 1990). "Even on a short-term basis, states may not rely on drugs to the exclusion of other methods to treat people with behavior problems." Id. at 1188. Moreover, it is a substantial departure from professional standards to rely routinely on seclusion and restraint rather than behavior techniques, such as social reinforcement, to control aggressive behavior. Id. at 1189. Seclusion and restraint should only be used as a last resort. Id.; Davis v. Hubbard, 506 F. Supp. 915, 943 (W.D. Ohio 1980).

Medicare and Medicaid regulations governing psychiatric hospitals require adequate staffing, record keeping, care, treatment, and discharge planning. 42 C.F.R. §§ 482-483. In addition, states must provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. Olmstead v. L.C., 527 U.S. 581, 607 (1999) (states are required to provide community-based treatment for persons with mental disabilities when a state's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities); see also Title II of the ADA, 42 U.S.C. § 12132 ("no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"), and its implementing regulations, 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"). Professional judgments should be made on a case-by-case basis regarding the

most appropriate setting in which individual patients should be placed. See, e.g., Thomas S., 902 F.2d at 254-55.

It is apparent that many OSH staff genuinely are concerned for the well-being of the persons in their care. These staff members display admirable dedication and undertake significant efforts to provide appropriate treatment and improve the lives of OSH patients. Nevertheless, it is also the case that significant and wide-ranging deficiencies exist in OSH's provision of care. Certain conditions and services at OSH substantially depart from generally accepted professional standards, and violate the constitutional and federal statutory rights of patients who reside there. In particular, we find that OSH: (1) fails to ensure reasonable safety of its patients; (2) fails to provide adequate mental health treatment; (3) engages in the inappropriate use of seclusion and restraints; (4) fails to provide adequate nursing care; and (5) fails to provide adequate discharge planning.¹ Many of these deficiencies stem from a system that does not have clear, specific standards of care or an adequate number of trained professional and direct care staff.

A. Inadequate Protection From Harm

Patients at OSH have a right to live in reasonable safety. See Youngberg, 457 U.S. at 315, 322. Yet, in our judgment, OSH fails to provide a living environment that complies with this constitutional mandate. Specifically, there is widespread patient-against-patient assault, unchecked self-injurious behavior, and a high rate of falls. In addition, the housing units contain environmental hazards, some of which pose risks of serious injury, illness, and death. The harm OSH patients experience as a result of these deficiencies is multi-faceted, and includes physical injury; psychological harm; excessive and inappropriate use of restraints; inadequate, ineffective, and counterproductive treatment; and excessively long hospitalizations. The facility's ability to address this harm is hampered by inadequate incident management and quality assurance systems.

1. Inadequate Incident Management

To protect its patients, OSH should have in place an incident management system that helps to prevent incidents and ensures appropriate corrective action when incidents do occur.

¹ Unless otherwise indicated, the findings apply to both campuses.

An effective incident management system depends on (1) accurate reporting, (2) thorough investigations, (3) tracking and trending of data, and (4) implementation and monitoring of effective corrective and/or preventive actions. The incident management system at OSH falls significantly short of these standards and, as a result, patients are exposed to actual and potential harm.

a. High levels of incidents

Certain types of incidents occur frequently at OSH. Facility records indicate that between January and December 2005, there were 392 patient-against-patient assaults. At the time of our tour in November 2006, these incidents appeared to be on the rise -- in the first ten months of 2006, OSH already had recorded 410 patient-against-patient assaults and thus was on pace for a 25% increase over the previous year.

Incidents of self-harm also are common at OSH. Although the facility did not provide data regarding the total number of these incidents, we found numerous references to self-injurious behavior during our document review. For example, H.M.² engaged in 26 episodes of self-injurious behavior/suicide attempts during a nine-month period in 2006. On seven of these occasions, H.M. was on 1:1 observation; on one occasion, she was on 2:1 observation.³ While on 1:1 observation, H.M. was able to wrap wires around her neck, swallow liquid cleaner, and climb under her bed and wrap a sheet around her neck. While on 2:1 observation, H.M. was able to, among other things, wrap yarn around her neck while taking a shower. D.I., another OSH patient, harmed herself 14 times between March and November 2006. A number of these incidents, including two occasions when D.I.

² To protect patients' privacy, we identify them by initials other than their own. We will separately transmit to the State a schedule that cross-references the initials with patient names.

³ As defined in OSH policy, "1:1 close observation" means that a staff member is assigned to monitor a patient's location and activities at all times and shall have constant visual and appropriate verbal contact with the patient at all times. While the term "2:1 close observation" is not defined in any OSH policy, it clearly suggests that patients subjected to this restriction have two staff members assigned to monitor them at all times. In light of the staffing issues discussed later in this letter, it is worth noting that 1:1 and 2:1 staffing is a labor-intensive and costly intervention.

attempted to choke herself, occurred while she was on 1:1 observation. It is incomprehensible how patients being supervised by staff members, whose only duty it is to monitor those patients, could be allowed to hurt themselves.

There also is a pattern of falls at OSH. Between January and November 2006, staff reported 654 of these incidents. Certain patients appear to be especially susceptible to falls, and yet OSH fails to take measures to prevent this harm. For instance, Q.T., a patient in his late 40s, fell 25 times between May 8 and August 15, 2006.

b. Incident reporting

As the above examples indicate, OSH patients frequently are subjected to the most basic kinds of harm. The first step in addressing this issue is proper incident reporting. At OSH, this process is governed by Policy 1.003, which is vague, confusing, and incomplete.

Policy 1.003 sets forth five categories of "reportable incidents": (1) actual injury to patients or visitors; (2) potential moderate or severe injury to patients or visitors; (3) damage to or loss of belongings of a patient, staff, or visitor as a result of a reportable incident; (4) security problems or suspicious events; and (5) falls. Not only are these categories extremely broad,⁴ Policy 1.003 makes no attempt to define the categories. Thus, individual staff members are left to determine whether a particular incident involves "potential moderate or severe injury," presents a "security problem," or constitutes a "suspicious event." With regard to falls, the policy is silent on whether all falls should be reported or only those that result in injury.

Incident reporting at OSH is further confused by the fact that the categories of incidents in Policy 1.003 do not track those listed on the facility's Incident Report form. Instead, the Incident Report form has its own separate and distinct categories of "reportable incidents": (1) medical; (2) behavioral; (3) laboratory; (4) security; and (5) environment of care. In addition, the Incident Report form has more than 90

⁴ Psychiatric facilities typically group incidents into categories such as: physical abuse, verbal abuse, sexual assaults, suicide attempts, deaths, patient-against-patient assault, elopement, medication error with adverse consequences, and transfer to a community hospital for medical treatment.

boxes that can be checked to further describe the incident. None of the terms contained in the 90 boxes, and only one of the five broad categories is defined by OSH policy.

The lack of clarity and conformity in OSH's incident reporting system virtually ensures that adverse events will not be reported or categorized consistently. And, without proper categorization, incidents cannot be reliably aggregated and analyzed.

In addition to presenting a confusing and undefined array of "reportable incidents," Policy 1.003 specifically precludes staff from reporting abuse and neglect through the normal incident reporting process. Instead, staff are to report allegations of abuse to the Superintendent by (1) taking a written copy of the allegation to the Superintendent's office, (2) emailing the allegation to the Superintendent, (3) calling the Superintendent's office, or (4) reporting the allegation in person to the Superintendent. There is no requirement that allegations of abuse and neglect be memorialized in writing or that they be collected, preserved, and tracked in a particular manner. OSH administrators know little about the frequency of abuse and neglect allegations or the outcomes of abuse and neglect investigations. Indeed, when we asked for a list of the abuse allegations that had been made during the 12 months preceding our tour, OSH could neither provide this information nor tell us how many allegations had been substantiated.

c. Incident investigations

Generally accepted professional standards dictate that facilities like OSH investigate serious incidents such as alleged abuse and neglect, serious injury, and death. Staff selected to conduct investigations should have a demonstrated competence in investigation techniques and a programmatic knowledge of mental health. Additionally, investigators should have no real or apparent conflict of interest, and no direct involvement with the incident, the alleged perpetrator, or the victim. During the investigation, evidence should be systematically identified, collected, preserved, analyzed, and presented. Investigators should attempt to determine the underlying cause of the incident by, among other things, reviewing staff's adherence to programmatic requirements such as policies and procedures for addressing the patient's behaviors and the implementation of the patient's treatment plan.

The investigative process at OSH significantly departs from these standards. As an initial matter, there is no requirement that OSH staff conduct even a cursory investigation of serious incidents. The only policy that touches on this topic is Policy 1.003, which requires numerous managers, including unit directors, unit mental health supervising RNs, program directors, and department directors to check the incident reports each day to evaluate them for clarity and to determine if any follow-up is necessary. If one of these managers believes follow-up is required, Policy 1.003 states that "the Incident Report Action Plan form . . . may be utilized for gathering information." There are no guidelines on how or when this form should be completed, and it appears that the form is used infrequently. For instance, out of the 161 incidents reported during September 2006, only four were flagged for follow-up. In short, Policy 1.003 yields an ill-defined process in which many people theoretically are responsible for investigating incidents and in which no one is, in fact, responsible. Not surprisingly, the facility conducts very few investigations.

One type of incident, however, is routinely investigated. State law requires that most allegations of abuse at OSH be investigated by the Office of Investigations and Training (OIT), which is part of the Oregon Department of Human Services and is not affiliated with the hospital. We were pleased with the quality of the OIT investigations we reviewed. We do, however, have two serious concerns with this system. First, it is not clear that OIT is notified of all abuse allegations. As explained above, OSH does not require that abuse allegations be memorialized in writing and does not have a policy or procedure that governs the maintenance of these allegations. Second, it appears that once OIT assumes responsibility for investigating an abuse allegation, OSH receives little feedback about the inquiry.

When done properly, investigations of serious incidents often raise programmatic issues that should be reviewed and evaluated. By failing to require investigations, establish procedures for conducting investigations, and follow up on the investigations conducted by OIT, OSH is missing both the opportunity to identify the underlying causes of incidents and the chance to correct deficiencies that may prevent similar incidents from occurring in the future.

d. Incident tracking and trending

Generally accepted professional standards require facilities like OSH to track and trend incident data to identify potentially problematic trends, and to identify, implement, and monitor

implementation of corrective action. The deficiencies in OSH's reporting process and the lack of an established investigatory process compromise its ability to do so.

Even when OSH identifies problematic trends, we found no evidence that adequate or appropriate remedies ensue. For example, OSH has data showing that certain housing units have a high incidence of patient-against-patient assaults. Yet, OSH has made no attempt to explain this disparity and thus cannot help managers on these units reduce the number of assaults. Similarly, OSH has identified certain patients who often are involved in patient-against-patient assaults and others who regularly engage in self-injurious behavior. The hospital has not, however, used this information to develop and implement behavior interventions to reduce these patients' harmful conduct. OSH's failure to take appropriate and timely action to address such trends suggests a pattern of institutional neglect and substantially departs from generally accepted professional standards.

2. Inadequate Quality Management

Generally accepted professional standards require that a facility like OSH develop and maintain an integrated system to monitor and ensure quality of care across all aspects of care and treatment. An effective quality management program must incorporate adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program also should include a process for developing a corrective action plan and a process for monitoring the effectiveness of corrective measures that are taken. Throughout this letter, we enumerate various failures at OSH to provide adequate care and treatment for its patients. With few exceptions, OSH has failed to identify these problems independently, or formulate and implement remedies to address them. Consequently, actual and potential sources of harm to OSH's patients are going unaddressed.

An adequate quality management program has two components: (1) quality assurance (QA), which focuses on evaluating compliance with basic standards of quality that are either internally or externally imposed; and (2) quality improvement (QI), which focuses on proactive self-evaluation and improvement efforts. The focus of our review was on the facility's QI efforts.

Each year, OSH develops a QI plan that identifies the facility's goals and objectives for improving patient outcomes and safety. Unfortunately, these efforts have resulted in few

significant and sustained improvements for OSH patients. Many of the QI initiatives are disjointed and inadequate. Others do not last long enough to achieve the desired system change. Additionally, much of the data collected through these efforts relates to process, not to the outcomes being achieved by patients or the adequacy of the protections, treatments, supports and services being provided. For instance, OSH has collected data about the number of restraint and seclusion episodes, but does not collect data about whether the use of such procedures was clinically necessary and justified. Similarly, as discussed above, OSH collects data about the number of patient-against-patient assaults and falls, but does not collect data that shed light on why these incidents occurred, or that can assist staff in preventing future incidents.

3. Failure to Provide a Safe Living Environment

OSH also fails to provide patients at the Salem campus with a safe living environment. Indeed, the Salem facility is rife with serious environmental hazards, many of which pose risks of serious injury, illness, and death. These environmental deficiencies exacerbate the deficiencies in patient care and treatment identified throughout this letter. In a facility serving people at risk of harming themselves or others, the environment should be free of physical risks and environmental hazards. See Youngberg, 457 U.S. at 324 (the state "has the unquestioned duty to provide reasonable safety for all residents and personnel within the institution"); Houghton v. South, 965 F.2d 1532, 1535 (9th Cir. 1992) ("Youngberg clearly established that institutionalized persons have a substantive due process liberty interest in 'reasonably nonrestrictive confinement conditions'"); Society for Good Will to Retarded Children v. Cuomo, 737 F.2d 1239, 1244 (2d Cir. 1984) (unsafe living conditions violated residents' constitutional rights); 42 C.F.R. § 482.41(a) ("The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured."). OSH egregiously departs from this generally accepted professional standard of care.

The physical plant at the Salem campus is in a state of severe deterioration and serious dilapidation. Indeed, as OSH's own consultants noted in a written report, (1) the buildings do not comply with current building and energy codes for secure psychiatric facilities; (2) the buildings do not comply with seismic requirements and will experience significant damage or collapse in the event of an earthquake; and (3) the patient wards are inefficient in layout and lack appropriate program space.

Moreover, many patient-occupied areas are not adequately ventilated or cooled, and it is fairly routine for indoor temperatures to exceed 90°F. These conditions present a serious risk of heat injury for OSH's patient population because many psychotropic medications affect heat regulation and because many elderly patients have chronic conditions that predispose them to heat illness such as heat stroke. Additionally, OSH's consultants acknowledge that the physical layout negatively impacts the ability of OSH staff to administer appropriate treatment programs and accordingly, creates a potentially unsafe environment for the patients and staff.

B. Failure To Provide Adequate Mental Health Care

OSH patients have a constitutional right to receive adequate mental health treatment. See Or. Advocacy Ctr., 322 F.3d at 1121. However, the mental health services at OSH substantially depart from generally accepted professional standards. Psychiatric practices at both campuses are marked by inadequate assessments and diagnoses, inadequate behavioral management services, and inadequate medication management. Each of these failures affects the quality and effectiveness of the patients' treatment plans which, in turn, are the foundation of an adequate mental health care program.

In accordance with generally accepted professional standards, each patient should have a comprehensive, individualized treatment plan based on the integrated assessment of mental health professionals. Treatment plans should define the goals of treatment, the interventions to be used in achieving these goals, and the manner in which staff 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 so that the patient may return to the community. Taken together, treatment plans constitute the standard against which a facility evaluates the effectiveness of the services it offers. In this sense, they are critical to a hospital's ongoing efforts at quality improvement.

Treatment planning must incorporate a logical sequence of interdisciplinary care: (1) the formulation of an accurate diagnosis based on adequate assessments conducted by all relevant clinical disciplines; (2) the use of the diagnosis to identify the fundamental problems that are caused by the diagnosed illness; (3) the development of specific, measurable and individualized goals that are designed to ameliorate problems and promote functional independence; (4) the identification of appropriate interventions that will guide staff as they work

toward those goals; and (5) ongoing assessments and, as warranted, revision of the treatment plan. To be effective, the treatment plan should be comprehensive and include input from various disciplines, under the active direction and guidance of the treating psychiatrist who is responsible for ensuring that relevant and critical patient information is obtained and considered.

OSH treatment planning substantially departs from these standards. From initial diagnosis and assessment, to the development of skills and functioning necessary for recovery and community reintegration, OSH's treatment planning fails to meet the fundamental requirements for the treatment and rehabilitation of its patients. As a result, patients' actual illnesses are not properly assessed and diagnosed; patients are not receiving appropriate treatment and rehabilitation; patients are at risk of harm from themselves and others; patients are subject to excessive use of restrictive treatment interventions; patients are at increased risk of relapses and repeat hospitalizations; and patients' options for discharge are seriously limited, resulting in unnecessary prolonged hospitalization, and, with respect to forensic patients, prolonged involvement in the criminal justice system.

1. Inadequate Psychiatric Assessments and Diagnoses

An effective treatment plan begins with a diagnosis that is clinically justified. If mental health professionals do not correctly identify a patient's psychiatric condition before developing a treatment plan, the treatment interventions will not be aligned with the patient's needs. A thorough assessment, however, establishes the parameters for individualized, targeted, and appropriate interventions that meet the medical, mental health, and psychological needs of the patient.

At a minimum, an initial assessment should include: (1) an adequate review of presenting symptoms and the individual's mental status; (2) a provisional diagnosis and differential diagnosis that provides a decision tree by which diagnosis and treatment options may be clarified over time; and (3) a plan of care that includes specific medication and/or other interventions to ensure the safety of the individual and others. As more information becomes available, the assessment must be updated to include: (1) a history of the presenting symptoms from the individual based on the individual's level of functioning and from collateral sources, as available; (2) the progression of the symptoms and setting within which the symptoms occur; (3) the relevant historical findings regarding the patient's

biopsychosocial functioning; (4) a review and critical examination of diagnostic conclusions made in the past as more information becomes available; (5) a review of medical and neurological problems, if any, and their impact on the current status of symptoms and treatment; and (6) a complete mental status examination.

In many cases, OSH simply does not conduct initial assessments. In the instances when they are performed, they often do not identify or prioritize specific mental health problems and needs. Moreover, many assessments do not provide a clinical justification for patients' psychiatric diagnoses. This, in turn, leads to inappropriate and inadequate care because patients can receive medication and other treatment for conditions they do not have. At the same time, their real mental illness can be left untreated, thereby exposing the patients to uncontrolled negative behaviors and unnecessary readmissions to OSH.

Perhaps as a result of these flawed initial assessments, OSH patients are routinely given tentative and unspecified diagnoses (often referred to as "rule out" or "not otherwise specified" (NOS) diagnoses) without evidence of further assessments or observations to finalize the diagnoses. Because different psychiatric conditions can have similar signs and symptoms, it is important for mental health professionals to address rule out and NOS diagnoses to ensure that a patient's treatment is appropriate for his or her actual mental health needs. At OSH, however, rule out and NOS diagnoses persist for months, with no sign of further diagnostic refinement. For instance, M.O. has a diagnosis of "psychosis NOS." Rather than refining this nonspecific diagnosis in an effort to provide treatment that targets M.O.'s illness, OSH has simply tried one medication after another.

OSH's failures in the preliminary stages of assessment and diagnosis as well as its failure to reassess patients for the purpose of refining diagnoses grossly depart from generally accepted professional standards. Patients receive, or are at risk of receiving, treatment that, at best, is unnecessary and, at worst, may actually exacerbate their mental illnesses. All the while, the actual mental illness is unaddressed, placing patients at risk of prolonged institutionalization and/or repeated admissions to the facility.

2. Inadequate Behavioral Management Services

Behavioral management plans at OSH are inadequate and not well integrated into overall treatment. Untrained staff lack the

skills necessary to handle the large number of very impaired patients who are dangerous to themselves or others or who have specialized needs.

We found numerous cases where patients exhibited self-injurious behavior (SIB) or aggressive behavior toward others for extended periods due to ineffective treatment plans. Contrary to generally accepted professional standards, staff effort is focused primarily on controlling dangerous patients rather than treating them and changing their behavior. Accordingly, staff resort to seclusion and restraint and secondarily, "as needed" medication, in lieu of appropriate treatment. Indeed, with the exception of several specific units (48B and 41A, B and C in Salem and 5A in Portland), OSH fails to use systemic behavioral (social learning) strategies to eliminate dangerous behaviors and teach patients more adaptive ways to behave. This problem is exacerbated by OSH's failure to provide a centralized system of oversight, review, feedback, and expert consultation, where necessary, to protect patients and ensure that adequate treatment is provided. Specific examples of OSH's inadequate behavioral management services include:

- N.N. has a history of life-threatening self-abuse. While at OSH, N.N. has swallowed 30 spoons and 17 pencils resulting in multiple abdominal surgeries. OSH's response to N.N.'s behavior is to place him in an ambulatory "suicide suit" restraint, which is designed to restrict the use of his hands. N.N. is also on a 2:1 close observation and is not allowed to eat with utensils (he uses celery stalks and taco chips). N.N.'s treatment plan is only a set of restrictions. It does not reflect any systematic, active effort to change his behaviors.
- F.T.'s record states that she engages in serious self-injurious and suicidal behavior. She was placed on 2:1 observation and was subjected to 11 episodes of seclusion and restraint between May and September 2006. There has been no change in F.T.'s treatment plan and no active intervention to teach her alternative behaviors.
- H.M. has a long history of SIB and suicide attempts. On various occasions, she has attempted to strangle herself with a shoe lace, yarn, and a telephone cord. She has also cut herself seriously. On July 3, and July 12, 2006, H.M. drank cleaning liquid even though she was being supervised on 1:1 close observation. Her

treatment plan does not analyze her behavior nor does it contain any strategies to change this pattern of conduct. The only plan is to keep H.M. on 1:1 close observation.

- Q.T. has Huntington's disease and a history of falls. His treatment plan consists of restraining him in a safety vest restraint that provides posture and torso support. OSH has not conducted a behavior assessment or implemented a program, such as gait training, to modify or eliminate his falls.
- O.Q. has a long history of severe self-harm and repeated dangerous assaults on others. She has been on 1:1 close observation for several years. On July 25, 2006, an OSH psychiatrist criticized this strategy, noting that "[w]hat appears to be a significant problem at this point is how dependent she has become on having a constant 1:1 and the difficulty of removing her from this. It would also seem as if some of her aberrant behaviors have been inadvertently reinforced by our own interventions." Notwithstanding this stark rebuke, O.Q.'s treatment team did not modify her treatment plan.
- B.O. has poor impulse control. He frequently pockets medications and gives them to other patients. He also attempts to feed inappropriate food to patients on special diets. Although successive treatment plans and progress notes reference these behaviors, there is no plan in place to address them.

OSH also fails address specific obsessional behaviors such as pica⁵ and polydipsia.⁶ Many OSH patients with these

⁵ Pica is a common eating disorder characterized by repeatedly eating non-food items. This disorder is prevalent in patients with mental illness and in those with cognitive impairments.

⁶ Polydipsia is a common disorder characterized by drinking excessive amounts of water to quench a constant thirst. This condition is prevalent in patients who spend significant amounts of time in psychiatric facilities, particularly those patients diagnosed with schizophrenia. This condition may cause incontinence, vomiting, seizures, water intoxication, or even death.

conditions are not treated in accordance with generally accepted professional standards. For example:

- D.D. has a history of polydipsia and obesity. Although his problems are noted in his medical record, D.D.'s treatment plan for polydipsia is that he will not gain more than six pounds per day for six months. There is no specific strategy to accomplish this goal. A progress note written shortly before our visit states that D.D. was found sitting at the water fountain, drinking cup after cup of water. A second progress note indicated a weight gain of 13 pounds in one day due to water intake.
- E.K.'s polydipsia is potentially life-threatening. His medical record reflects significant episodes of weight gain associated with water consumption. During a two month period in 2006, E.K. was allowed to gain extraordinary amounts of weight by drinking water even though, at times, he was on 1:1 close observation. On June 14, E.K. had a grand mal seizure due to water consumption; on June 21, he gained 11 pounds; on June 22, he gained 14 pounds; on July 11, he gained 10 pounds; on July 13, he gained 10 pounds; and on July 14, he gained 12 pounds in three hours. A July 23, 2006 progress note states that "for past ½ hour pt has been drinking water at fountain despite being on 1:1." A doctor's note from that day indicates that E.K. has recurrent episodes of seizures.
- K.L. continues to exhibit significant and constant pica behavior. Our review of her medical record revealed that during a period of one month she swallowed speaker wire, several buttons, and glass particles. Pica is listed in K.L.'s chart as her primary barrier to being discharged from OSH, yet this behavior is not being treated, jeopardizing K.L.'s health and resulting in her prolonged institutionalization.

3. Inadequate Medication Management and Monitoring

Medication practices at OSH substantially depart from the generally accepted professional standards. These standards require 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. Medications should be carefully monitored and tracked. Medication changes, as well as the rationale for the changes, should be documented in a physician's order. All lengthy administrations of medication should be periodically evaluated to assess their efficacy. OSH's practices fall far short of these requirements.

OSH's inappropriate psycho-pharmacological practices have led to the inappropriate use of PRN (pro re nata or "as needed") medication. OSH frequently administers PRN medication that is not targeted to specific symptoms of mental illness, and lacks adequate justification. For example, B.N. was routinely given an antipsychotic, an antidepressant, and a mood stabilizing drug on an "as needed" basis even though her psychiatrist expressly questioned the need for these medications. Another patient, Q.S., was given prescribed PRN vicodin, a highly addictive narcotic pain medication, despite the fact that his chart states that he should not be given PRN pain medication, aside from acetaminophen, because of his propensity for addiction.

Moreover, rather than prescribing antipsychotic medications and benzodiazepines for their specific purpose -- 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. Generally accepted professional standards instruct that PRN psychotropic medications should be used only as a short-term measure to relieve a patient in acute distress, not as a means to escape mild, possibly healthy discomfort, as a repeatedly-deployed substitute for treatment, or as punishment. As noted above, OSH's use of PRN medications departs from these standards. Because OSH's psychiatrists rarely analyze the use of PRN medications and patients' reactions to them, they cannot refine patients' diagnoses and adjust routinely administered medications. Without such monitoring, patients are at risk of being overly and/or improperly medicated. This practice constitutes chemical restraint, which violates federal regulations. See 42 C.F.R. § 482.13. This practice also substantially departs from generally accepted professional standards.

K.L. is one patient who is routinely subjected to chemical restraint. She received PRN medication 26 times in April 2006, 22 times in May 2006 and 35 times between August 28 and September 24, 2006 to address her agitation and aggressive behavior. Another example is D.C., a 34-year-old woman with anorexia nervosa, polysubstance abuse, major depression, and post traumatic stress syndrome. Although admittedly a complicated patient, D.C. receives multiple medications that have overlapping purposes. For instance, D.C.'s PRN medications include at least four different drugs for anxiety and agitation. This dependence on the nonspecific use of PRN medication also is reflected in the case of A.A., who receives PRN medications for agitation, aggression, psychosis, and anxiety. It is not clear from the doctor's orders or progress notes how OSH is treating each of A.A.'s separate, but overlapping conditions or how PRN medications should be prioritized to avoid over-medicating this patient.

Generally accepted professional standards require that facilities like OSH adopt and incorporate the necessary protections and safeguards to ensure that patients are afforded safe and effective pharmacological treatment. Hospitals such as OSH must have mechanisms to: (1) monitor practitioners' adherence to specific and current guidelines in the use of each medication; (2) report and analyze adverse drug reactions; and (3) report, analyze, and document actual and potential variations in the prescription, transcription, procurement/storage, dispensing, administration, and documentation categories of medication. To the extent that these mechanisms even exist at OSH, they are inadequate.

OSH fails to provide any systematic monitoring to ensure appropriate, safe, and effective medication use in the facility. Furthermore, OSH's medication guidelines, which are the basis of any effective medication monitoring system, are seriously deficient. They fail to provide necessary monitoring requirements for a variety of risks associated with psychotropic medications, including: (1) the adverse metabolic effects (such as weight gain and Type 2 diabetes); (2) the risk of myocarditis, a potentially lethal inflammation of the heart muscle; and (3) potentially harmful drug interactions with anticonvulsants, diets, and tobacco smoking.

OSH's current system to track and analyze adverse drug reactions is also deficient and seriously under-reports problems. The data collection tool does not include basic components, such as a definition of an adverse drug reaction, a severity scale, a probability scale, or a description of patient outcome. There

are no established thresholds triggering analysis of adverse drug reactions. There is no data analysis to indicate individual or group practitioner trends. And, there is no evidence that any data on adverse drug reactions have been used for performance improvement activities.

Moreover, OSH fails to provide adequate protection against medication errors. Medication errors, when tracked at all, are not used for staff assessment or performance improvement. For example, the current system ignores a number of substantial variances, such as procurement and storage, monitoring, and documentation. It does not incorporate information or analysis regarding critical breakdown points or individual or group practitioner trends. Finally, it does not appear that variance data have been used for performance improvement activities, and there is no evidence of any meaningful corrective actions as a result of variance analysis.

C. Inappropriate Use Of Seclusion And Restraints

The right to be free from undue bodily restraint is the core of the liberty protected from arbitrary governmental action by the Due Process Clause. Youngberg, 457 U.S. at 316. Thus, the State may not subject residents of OSH to seclusion and restraint "except when and to the extent professional judgment deems this necessary to assure [reasonable] safety [for all residents and personnel within the institution] or to provide needed training." Id. at 324. Generally accepted professional standards require that seclusion and restraints: (1) will be used only when persons pose an immediate safety threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted; (2) will not be used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff; (3) will not be used as a behavioral intervention; and (4) will be terminated as soon as the person is no longer a danger to himself or others. OSH's use of seclusion and restraints substantially departs from these standards and exposes patients to excessive and unnecessarily restrictive interventions.

1. Planned Seclusion and Restraint

OSH's permissive approach to seclusion and restraints is perhaps best illustrated by its use of planned seclusion and restraint. According to OSH policy, "planned seclusion and/or restraint may be one component of a patient's comprehensive treatment plan, when the patient suffers from significant repetitive, maladaptive behaviors." The policy specifies that

"planned seclusion and/or restraint must be developed as an individualized therapeutic intervention that is integrated into the patient's comprehensive treatment plan." The policy further states that "this practice is designed to provide a therapeutic environment . . . , thus enabling the implementation of other components of the patient's comprehensive treatment plan." For the reasons discussed below, this policy is in stark contract to generally accepted professional standards.

In practice, planned seclusion/restraint often is the only component of a patient's treatment plan. It is an unrefined and unlawful strategy that consists of restricting patients to a bedroom or seclusion room for weeks and sometimes months at a time. Once a patient is placed in planned seclusion, staff typically make little or no effort to develop treatment plans that address the problematic behaviors in less restrictive ways. Indeed, both staff and patients seem to accept the fact that patients in planned seclusion will remain there unless and until there is some spontaneous change in the patients' behavior. Furthermore, because patients in planned seclusion have few opportunities to demonstrate improvement, many of them remain in seclusion indefinitely.

One such patient is T.Q., who was placed in planned seclusion on November 30, 2005 and remained there at the time of our on-site visit in November 2006. During this 12-month period, T.Q. was confined to a seclusion room and allowed out only with ambulatory restraints and 2:1 close observation. According to her treatment plan, T.Q. is "a violence risk and will be a violence risk even with extended periods of abstinence." This statement reflects staff's apparent belief that T.Q. cannot be treated. Thus, it is likely that planned seclusion will remain the facility's intervention of choice for this patient, and T.Q. will continue to lead her life alone and institutionalized.

U.W. also spent more than one year in planned seclusion. Between December 2004 and December 2005, he was restricted to his room and allowed out only with ambulatory restraints. In December 2005, his program changed to permit U.W. to leave his room for brief periods on 2:1 close observation. The planned seclusion, however, remained in place until February 2006. Other patients subjected to planned seclusion include K.B., who was in planned seclusion from July 15, 2005 through at least June 2006 (the date of the last reviewed record), and C.S., who was placed in planned seclusion on December 7, 2005 and remained there until at least July 2006 (the date of the last reviewed record).

We found no evidence to suggest that any of the patients placed in planned seclusion/restraint had active treatment plans to address the violent conduct that resulted in these extreme measures. For instance, the treatment plan for N.T. simply directs staff to place him in a restraint bed when he bangs his head. The plan does not include any behavioral interventions to address this self-injurious conduct. Despite the fact that N.T. was placed in restraints nine times between February 18 and August 23, 2006, there is no sign that his behavior is improving.

Given the deleterious effects of seclusion and restraint, and the fact that these measures restrict patients' rights and their ability to receive appropriate care, generally accepted professional standards require that institutions like OSH will reduce their use of seclusion/restraint and address behavior problems with less intrusive and restrictive strategies. With its use of planned seclusion/restraint, however, OSH has taken the opposite approach. It is worth noting that no member of the Department of Justice site visit team had ever encountered the use of continuous seclusion as a planned treatment strategy. The fact that OSH condones this unconstitutional practice reveals much about the facility's permissive attitude towards the use of seclusion and restraints.

2. Use of Seclusion and Restraint as Informal Alternatives to Treatment and as Punishment

Even when seclusion and restraint are not formal parts of a patient's treatment program, OSH often uses these measures as substitutes for proper treatment. Indeed, between January and June 2006, OSH staff used seclusion and/or restraints 393 times. On 83 of these occasions, patients were placed in prone restraints, which are dangerous and can be deadly, before being moved to a seclusion room. Many patient charts identify frequent episodes of seclusion and restraint without related documentation indicating that the team adequately assessed the patient, developed and/or reviewed the treatment plan, or considered alternative interventions.

For instance, S.I. had seven episodes of seclusion/restraint between March and August 2006. There is no evidence that staff attempted to identify the cause of his aggressive, violent behavior or developed a treatment plan to address it. Similarly, during a seven-month period in 2006, B.Q. was placed in seclusion ten times and was almost constantly on 1:1 or 2:1 close observation. Yet, staff proposed no intervention strategies and made no changes to his treatment plan. Between July and August 2006, M.O. had 18 episodes of seclusion for self-injurious

behavior, but staff made no effort to address her dangerous conduct with a specific treatment plan. N.U. suffers from command hallucinations to kill others and a record of seriously injuring other people. His treatment plan is to predict or control aggression by directing him to time out, seclusion, or close observation, primarily at his request. There is no proactive strategy to change his behavior.

OSH's frequent use of seclusion and restraint supports our finding that many OSH patients have erroneous diagnoses and/or inappropriate treatment plans. The facility's reliance on seclusion and restraint as treatment strategies is inappropriate, ineffective, extraordinarily detrimental, and, at times, life-threatening.

3. Use of Ad Hoc Restrictive Measures

Another concern about seclusion and restraint at OSH is the widespread use of ad hoc restrictive measures such as "suicide suits," "safety status," "east end restriction," "the 10 foot rule," and "security hold." These unconventional measures are not defined or described in OSH policy. Rather, they appear to be improvised responses to patient behavior that, over time, have been adopted throughout the facility.

Among the patients subjected to these ad hoc restrictions is N.N., who was admitted to OSH from the Department of Corrections with a history of severe, life-threatening self-abuse. At the time of our visit, N.N. was required to wear a "suicide suit" -- a device that restricted his hands so he could not do further damage to a stomach wound. There is no evidence that OSH has made any systematic, active effort to change his behavior or address it through less-restrictive means.

OSH staff use ad hoc measures with S.D. According to his chart, S.D. exhibits excessive anger and explosive outbursts, although no such episodes were documented in the 12 months before our visit. S.D.'s behavior plan specifies: "If [S.D.] has an explosive or angry outburst with staff and requires more than 1 cue to calm or redirect himself, regardless of the cause of the outburst, his level will be dropped to safety status for 3 days. If during an angry outburst he throws, or harms objects, his level will be dropped to safety status for 7 days." It is not clear exactly what "safety status" entails -- presumably close observation and restriction in movement. In any event, the conduct described above hardly merits three or seven days of restriction. This appears to be punitive.

K.N., E.K., and Q.Z. are among the patients placed on "east end restriction." Under this restrictive measure, patients must remain on one end of their housing unit, except to shower and use the restroom. Although east end restriction does not seem to result in improved behavior, staff typically make little effort to develop proactive treatment plans for patients under this restriction.

W.W. is aggressive and assaultive. He also exposes his genitals to female staff. His treatment plan includes a "10 foot rule" and "security hold." These restrictions are not defined in any OSH policy or procedure, but they appear to be designed to keep W.W. at a safe distance from other patients. These procedures were implemented consistently for two months and then terminated without any explanation.

Not only are the makeshift measures described above often used in lieu of active treatment, they almost always are ineffective. Moreover, because there is no central oversight, each individual unit is free to develop its own restrictive practices without regard to OSH policy. As a result of this disorganized, unmonitored system, OSH patients are subjected to unnecessary restrictions.

4. Failure to Assess Patients in Seclusion and Restraint

OSH also fails to comply with its own policy and generally accepted professional standards which require staff to constantly observe patients who are in restraints. For instance, on June 13, 2006, D.I. used a plastic fork to lacerate her wrist. Following this incident, D.I. was restrained and placed in seclusion. The record notes that she made herself vomit as soon as staff left the area. Failure to monitor restrained patients places them at risk for serious injury. In D.I.'s case, she could have choked to death while unsupervised.

D. Inadequate Nursing Care

Although OSH patients are entitled to receive adequate health care, see Youngberg, 457 U.S. at 315, the facility's nursing services substantially depart from generally accepted professional standards. OSH is suffering from a chronic nursing shortage, which has caused a number of serious deficiencies in the nursing services provided to patients. Specifically, nursing staff: (1) fail to provide basic care such as monitoring vital signs and responding in a timely manner to changes in patients' medical status; (2) fail to actively participate in the treatment team process by providing feedback on patients' responses, or

lack thereof, to medication and behavioral interventions; (3) fail to properly document and monitor the administration of medications; and (4) fail to implement adequate infection control procedures. These deficiencies expose OSH patients to harm and a significant risk of harm.

1. Staffing

Many of the shortcomings in nursing care are exacerbated by the lack of adequate staffing, support, training, and supervision. The chronic shortage of nursing staff at OSH has received press coverage, and the Associate Director of Nursing at the facility referred to it as a "critical staffing crisis." Generally accepted professional standards require facilities like OSH to provide sufficient nursing staff to, at a minimum, protect patients from harm, ensure adequate and appropriate treatment, and prevent unnecessary and prolonged institutionalization. OSH, however, routinely compromises its patients' care and treatment by failing to satisfy these requirements.⁷

A recurring issue is that OSH has no formal mechanism with which to analyze the specific needs of each unit and determine the number and skill mix of nursing staff that each unit requires.⁸ Instead, nursing staff seem to be assigned to particular units based upon their schedules and availability without serious regard to patients' needs.

In an effort to triage its staffing issues, OSH uses a significant amount of overtime. Indeed, during the first six months of 2006, overtime hours at the facility amounted to approximately 41 full time equivalent positions. The use of overtime is particularly dangerous because staff who work multiple and contiguous shifts in a given day or week are more likely to be fatigued, less capable of making accurate clinical decisions, more likely to make medication errors, more likely to be injured and cause injuries, and less inclined to provide active treatment and interventions to patients.

⁷ We note that the State has convened a group of nursing professionals to advise the Department of Human Services on ways to encourage nursing students to prepare for and seek employment at OSH. This is commendable.

⁸ OSH has three levels of nursing staff: (1) registered nurses (RNs); (2) licensed practical nurses (LPNs); and (3) medical health technicians (MHTs). RNs are the most skilled nursing staff and often are required to supervise LPNs and MHTs.

For instance, when completing seclusion and restraint review forms, staff repeatedly identify insufficient staffing as a serious concern. Staff indicate that they feel unsafe during emergency seclusion and restraint procedures, and, in a number of cases, staff were injured because there were not enough staff to ensure the safety of those present.⁹ Staff also mention personnel shortages when explaining medication errors. For example, on January 6, 2006, a nurse gave Q.T. a dose of medicine even though the doctor had discontinued the order for it. At the time the error occurred, the nurse was caring for two seriously ill patients. She cited workload as a factor that contributed to this mistake. In another case, K.C. received two medications in error. The mistake reportedly was made because an employee working an overtime shift failed to confirm K.C.'s identity before giving him the medication. On May 16, 2006, O.N. was given twice the amount of medication the doctor ordered. There was only one RN on the unit at the time and she was an agency nurse. An in-house preliminary staffing analysis conducted during 2006 confirms staff's conclusions. The report correlated the use of overtime with increased use of seclusion and restraints, staff injuries, and patient grievances.

OSH also uses float staff to address staffing shortages. Like the use of overtime, this practice is risky because float staff are less familiar with the patients in their care and thus are more likely to make mistakes with medications and less likely to rapidly identify precursors to behavioral issues. OSH documents are replete with examples of such harm. For instance, on January 28, 2006, B.T. received the wrong medication from a float staff member who was unfamiliar with both the unit and B.T. B.T. had to be closely monitored to ensure there was no decrease in his blood glucose levels as a result of the medication error.

In short, OSH's staffing shortages fall dangerously below the minimum levels required to provide basic levels of nursing services and care. Unless and until OSH hires, trains, and supervises a sufficient number of nursing staff, patients will continue to receive inadequate care.

⁹ For example, on April 24, 2006, several staff were injured while trying to place E.E. in seclusion. Other staff were injured during an April 9, 2006 episode with patient Q.F. and a January 25, 2006 episode with patient T.I.

2. Failure to Provide Basic Care

Effective medical services depend on timely, thorough assessments and monitoring. Nurses are a primary source of information regarding patients who need medical attention. At OSH, however, nursing staff often fail to provide even the most basic care, opting instead for a reactive approach in which patients' medical needs are addressed only after problems develop. Consequently, residents are exposed to a significant risk of harm and often suffer preventable injuries and illnesses. For example:

- At 3:20 a.m., an outside provider that performs laboratory work for OSH informed the facility's nursing staff that S.C. had toxic levels of norclozapine and clozapine in her blood. Upon receipt of this information, the RN assessed S.C. and obtained vital signs. The RN was concerned about S.C.'s pulse, which seemed high given that she was resting in bed, and informed the doctor. The doctor agreed to evaluate S.C. in the morning, and the RN agreed to monitor the patient throughout the night and to alert the day shift RN to the patient's status. Yet, there was no additional documentation for 24 hours, suggesting that no one monitored the patient's vital signs for an entire day.
- The progress notes for E.N. discuss the following incident. E.N. got out of bed to use the restroom. After walking a few steps, he got down and crawled to the nursing station where he complained of shortness of breath. After staff directed him to a nearby restroom, E.N. got up and walked there. At no time did staff call an RN to assess this patient in response to his complaint of shortness of breath. Two hours later, E.N. was found in his bed "shaking," with a fever and a high pulse rate. He was transferred to a local hospital for treatment.
- Around 2:30 a.m., N.C. was found on the floor of his room with a large laceration on his head. He was sent to the emergency room for treatment. Although staff did not witness the injury, N.C.'s record states that he sustained the injury when he fell out of bed. The record also states that earlier in the day, N.C. was hesitant to stand up on several occasions and, in fact, did not stand at all the day after the injury occurred. There was no evidence that nursing staff conducted an assessment to determine why N.C. was feeling unsteady.

3. Failure to Provide Feedback to Treatment Teams

In order for treatment teams to evaluate the adequacy of implemented interventions, nursing and other unit-based staff must monitor, document, and report patients' symptoms. The psychiatrists and other physicians who prescribe medication, and the psychologists and therapists who oversee therapeutic interventions, rely on staff to provide this information. In the absence of such communication, the treatment teams lack significant information regarding dangerous behavior and the efficacy of interventions.

Unfortunately, the culture and structure at OSH do not facilitate communication between treatment team members. Most significantly, as discussed earlier, OSH treatment plans do not adequately define the criteria or target variables by which treatments and interventions are to be assessed, nor do the plans identify how and when these factors should be monitored. Accordingly, nursing staff do not have the tools that are necessary to monitor patients' problems and symptoms. Compounding this problem is the fact that nursing staff members are not required or encouraged to communicate with other team members in an effort to anticipate and minimize problems.¹⁰ As a result, both nursing staff and treatment teams respond to patient needs, if at all, in a largely reactive way. Consequently, OSH patients are subjected to excessive and inappropriate uses of medication, seclusion and restraints, and inadequate and ineffective therapeutic interventions.

4. Medication Administration

Generally accepted professional standards require that staff properly complete the Medication Administration Records (MARs). Among other things, MARs list the current medications, dosages, and times that medications are to be administered. Generally accepted professional standards also dictate that staff sign the MARs at the time the medication is administered. Properly completing the MARs is fundamental to maintaining patient safety and reducing the likelihood of medication errors and adverse drug

¹⁰ For instance, progress notes for U.N. indicate that she secured a container of Ajax, several cups of liquid soap, and disinfectant, which she used to "wash" her hands to the point of skin breakdown. She also was observed eating and microwaving soap, and pouring it on the floor. There is no evidence that nursing staff brought these behaviors to the attention of the treatment team in an effort to address them.

effects. If staff fail to do so, it may result in patients not receiving medications or receiving them multiple times.

We identified many instances in which staff documented that medication had been given when, in fact, the patient had never received it. One example is the March 10, 2006 episode in which the MAR indicated that T.U. had received his Digoxin and Omeprazole, but the medication was later found in the medication cart. Digoxin is used to treat heart failure. A few days later, on March 19, 2006, H.T. failed to receive her nighttime dose of the sleep aid Ambien although the MAR reflected that it had been given. Documenting medication as given before actually administering it is a dangerous practice which substantially departs from generally accepted professional standards.

Other dangerous medication administration practices at OSH include "setting up" medications (i.e., preparing medication in advance of administration) and "borrowing" medications (i.e., giving a dose of a patient's medication to another patient). Setting up medication often contributes to medication errors because it encourages staff to simply hand over medications when the patient arrives without validating what is being given to whom. Indeed, there are numerous examples of staff giving medications to the wrong patients or giving incorrect doses. In some cases, these mistakes had serious consequences. On March 14, 2005, D.H. received the wrong medication and was transported to the emergency room because of over-sedation and altered vital signs. On July 18, 2006, S.N. was sent to the emergency room after receiving a double dose of medication and temporarily losing consciousness. S.M. received the wrong medication on June 26, 2006 and had to be monitored every two hours. On February 18, 2006, nursing staff gave X.X. three times the amount of medication he was supposed to receive. Borrowing one patient's medications to give to another is similarly reckless. It deprives patients of access to their medications and can lead to errors in dosage and timing.

5. Infection Control

Generally accepted professional standards require adequate infection control. OSH's plan for infection control is inadequate and places patients and staff at substantial risk for exposure to dangerous diseases. OSH's failure to prevent and control infections in the hospital places patients, staff, and visitors at risk of harm, including death. Indeed, of the 28 patient deaths that occurred between January 2005 and August 2006, 15 were from pneumonia, an infection-related condition.

Neither OSH staff nor its patients comply with generally accepted standards for hand washing. Indeed, documents we reviewed referenced nursing staff who administered medication and engaged in other patient care activities without washing their hands. Other documents noted problems with mice in patients' rooms, norovirus outbreaks,¹¹ scabies outbreaks, and failure of staff to clean up "messes" in seclusion rooms.

In addition, problems with medication administration have lead to errors with antibiotics where patients did not receive their full course of medicine or did not receive their medicine in a timely manner. These errors lead to increased risk of treatment failure and antibiotic resistance.

E. Inadequate Discharge Planning And Placement In The Most Integrated Setting

Within the limitations of court-imposed confinement, federal law requires that OSH actively pursue the timely discharge of patients to the most integrated, appropriate setting that is consistent with the patients' needs. Olmstead, 527 U.S. at 607.¹² Thus, at the time of admission and throughout a patient's

¹¹ Noroviruses are a highly contagious group of viruses that cause the stomach flu.

¹² We are aware that the State has entered into two settlement agreements that address the discharge of patients from OSH. The first agreement, signed in December 2003, arose out of the Miranda B. litigation and concerns patients who are civilly committed. See Miranda B. v. Kulongoski, No. CV00-1753-HU (D. Or. Dec. 19, 2000). The second agreement, signed in April 2006, arose out of a class action lawsuit concerning forensic services at OSH. Harmon v. Fickle, No. CV05-1855-BR (D. Or. Dec. 8, 2005). Among other things, both agreements require the State to increase the number of community placements and to take steps to facilitate the discharge or conditional release of OSH patients in a clinically appropriate manner and within a reasonable time frame. These agreements, however, do not obviate the need for federal review. Indeed, our independent evaluation identified a number of barriers and deficiencies in OSH's procedures, services, and treatment that hamper the State's efforts to develop and maintain an adequate community integration program. Moreover, it is our understanding that the State has been extremely slow to implement the reforms it agreed to in the Miranda B. and Harmon agreements. In light of these reported

stay, OSH should (1) identify, through professional assessments, the factors that likely will foster viable discharge for the patient, and (2) use these factors to drive treatment planning and intervention. Without clear and purposeful identification of such factors and related issues, patients will be denied rehabilitation and other services and supports that will help them acquire, develop, and/or enhance the skills necessary to function in a community setting.

The discharge planning process at OSH falls significantly short of these standards of care. Treatment teams typically do not consider or integrate criteria for discharge into treatment planning. Consequently, many patients whose psychiatric conditions are largely under control remain hospitalized because of poor daily living skills, aggressive conduct, incontinence, inadequate dietary management, failure to take medication, and/or other behaviors that prevent discharge and community reintegration. Although such behaviors often can be resolved with proper treatment, OSH rarely addresses these issues in patients' treatment plans or in the facility's discharge planning. For instance:

- U.T. has been refused admission into community facilities because of agitated and aggressive behavior. There appears to be no plan to address this conduct and no acknowledgment that it is an impediment to discharge. Instead, U.T.'s chart reflects the apparent consensus that he will never be discharged from OSH.
- T.I. also remains hospitalized because of aggressive behavior. During his three years at OSH, staff have controlled this behavior with sedating medications. Although T.I.'s chart notes that sedation is a problem, this issue is not adequately addressed in the overall treatment plan. Moreover, there is no specific behavior plan to address the aggressive conduct that is the reason for T.I.'s continued institutionalization.
- N.N. has been hospitalized at OSH since December 2005. Shortly after he was admitted, staff developed and implemented a behavior plan to reduce N.N.'s intrusive and threatening behaviors. This seemingly successful

delays, we are reluctant to rely on those agreements to correct the constitutional deficiencies in OSH's discharge planning process.

plan, however, was discontinued for reasons that are unclear. Currently, there is no behavior plan that addresses the conduct that is a barrier to N.N.'s discharge.

- U.U. has been hospitalized since April 2002. According to his chart, he no longer exhibits symptoms of his psychiatric disorder. However, U.U. has a history of substance abuse and refuses to participate in programs to address this issue. OSH staff will not recommend U.U. for discharge because he has a negative attitude and does not want to leave the hospital. Yet, there is no plan to resolve these issues.
- N.T. and N.U. are incontinent of bowel and urine. Neither patient has a plan to address this issue.

Although we certainly do not advocate the release of dangerous persons into the community, we find that OSH often does not take appropriate steps to address the aggressive conduct that keeps many of its patients institutionalized. The failure to provide adequate, individualized treatment and discharge planning for these and other patients deviates from generally accepted professional standards and contributes to extended hospitalizations, unsuccessful community placements, and a high likelihood of readmission. Patients are harmed or exposed to the risk of harm by the effects of prolonged institutionalization and by being denied a reasonable opportunity to live successfully in the most integrated, appropriate setting.

It is worth noting that OSH has a utilization review committee and processes by which to identify and track civil and forensic patients who are ready for discharge. The facility also has increased vocational and educational programming and, shortly before our tour, initiated at least two specialized treatment programs to address common barriers to discharge -- one for sex offenders and one for patients with co-occurring mental illness and substance abuse disorders. It is our understanding, however, that these opportunities are limited, at least informally, to patients who are on the placement list. Thus, these changes do little to address the lack of early, consistent, systematic discharge planning and intervention at OSH. Moreover, because these changes are relatively new, it is unclear whether they will, in fact, improve the timely transition of patients to community settings.

Another difficulty with OSH's discharge planning is that the facility does not provide the follow-up supports and services that are essential for successful transitions to the community. Patient records rarely discuss the provision of transition supports, and when discharged, patients are ill-equipped to succeed in community placement. Furthermore, in at least one instance, OSH placed a patient on the discharge list notwithstanding the fact that his psychiatric treatment was in flux and the fact that he appeared likely to harm himself or others.¹³

A final problem with discharge planning at OSH grows out of the contracting arrangement between the State and the privately-owned and -operated community providers. At present, these providers are allowed to subjectively select or "cherry pick" their residents from the OSH patients who have met the criteria for discharge and are on the hospital's placement list. Predictably, when given a choice, providers often reject those patients who appear most challenging. As a result, some patients remain at OSH for months or even years after having met the criteria for discharge. Indeed, at the time of our tour, there were 18 civil patients who had been on the discharge list for more than one year and 15 more who had been on the discharge list for more than six months. Thirty-one forensic patients had been waiting more than three months for a transfer.

The detrimental effect on individual patients of this prolonged waiting and frequent rejection is documented repeatedly in their clinical records. Patients' despair, anger, and agitation about having been turned down by community providers become a part of their illness. These and other effects of prolonged institutionalization result in harm or a serious risk of harm to OSH patients. Unless and until OSH implements a discharge planning program that results in timely discharge to appropriate community placements, the State is in violation of Olmstead.

¹³ This patient, D.K., has a long history of schizoaffective disorder. In response to symptoms of his mental disorder, he enucleated his left eye and severely damaged his right eye leading to functional blindness. At the time the team identified him for discharge, D.K. frequently experienced delusional thoughts of self-harm, often was verbally threatening to staff, and was on several antipsychotic medications without justification.

III. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of the patients at OSH, the State of Oregon should promptly implement the minimum remedial measures set forth below:

A. Protection From Harm

OSH should provide its patients with a safe and humane environment and protect them from harm. At a minimum, OSH should:

1. Create or revise, as appropriate, and implement an incident management system that comports with generally accepted professional standards. OSH should:
 - a. Create or revise, as appropriate, and implement comprehensive, consistent incident management policies and procedures that provide clear guidance regarding reporting requirements and the categorization of incidents, including allegations of abuse and neglect;
 - b. Develop and implement policies and procedures that require all abuse and neglect allegations to be memorialized in writing and forwarded to the Office of Investigations and Training ("OIT") upon receipt;
 - c. Require all staff to complete successfully competency-based training in the revised reporting requirements;
 - d. Create or revise, as appropriate, and implement thresholds for patient injury/event indicators, including patient-against-patient assaults, self-injurious behavior and falls, that will initiate review at both the unit/treatment team level and at the appropriate supervisory level and that will be documented in the patient medical record with explanations given for changing/not changing the patient's current treatment regimen;
 - e. Create or revise, as appropriate, and implement policies and procedures addressing the investigation of serious incidents. Such

policies and procedures shall include requirements that investigations of such incidents be undertaken and that they be comprehensive, include consideration of staff's adherence to programmatic requirements, and be performed by independent investigators;

- f. Require all staff involved in conducting investigations to complete successfully competency-based training on technical and programmatic investigation methodologies and documentation requirements necessary in mental health service settings;
 - g. Monitor the performance of staff charged with investigative responsibilities and provide technical assistance and training whenever necessary to ensure the thorough, competent, and timely completion of investigations of serious incidents;
 - h. Develop and implement a reliable system to identify the need for, and monitor the implementation of, appropriate corrective and preventative actions addressing problems identified as a result of investigations; and
 - i. Review, revise, as appropriate, and implement policies and procedures related to the tracking and trending of incident data, including data from the abuse and neglect allegations investigated by OIT, to ensure that appropriate corrective actions are identified and implemented in response to problematic trends.
2. Develop and implement a comprehensive quality improvement system consistent with generally accepted professional standards of care. At a minimum, such a system should:
- a. Collect information related to the adequacy of the provision of the protections, treatments, services, and supports provided by OSH, as well as the outcomes being achieved by patients;
 - b. Analyze the information collected in order to identify strengths and weaknesses within the current system; and

- c. Identify and monitor implementation of corrective and preventative actions to address identified issues and ensure resolution of underlying problems.
3. Conduct a thorough review of all units to identify any potential environmental safety hazards, and develop and implement a plan to remedy any identified issues. At a minimum, OSH should:
 - a. Ensure that the buildings at the OSH Salem campus comply with current building codes for secure psychiatric facilities;
 - b. Ensure that all buildings housing patients comply with seismic requirements;
 - c. Develop and implement plans to ensure that all patient wards are adequately ventilated and cooled, consistent with patients' medical needs; and
 - d. Eliminate all suicide hazards in patient bedrooms and bathrooms.

B. Mental Health Care

1. Psychiatric Assessments and Diagnoses

OSH should ensure that its patients receive accurate, complete, and timely assessments and diagnoses, consistent with generally accepted professional standards, and that these assessments and diagnoses drive treatment interventions. More particularly, OSH should:

- a. Develop and implement comprehensive policies and procedures regarding the timeliness and content of initial psychiatric assessments and ongoing reassessments. Ensure that initial assessments include a plan of care that outlines specific strategies, with rationales, including adjustments of medication regimens and initiation of specific treatment interventions.
- b. Ensure that psychiatric reassessments are completed within time-frames that reflect the individual's needs, including prompt evaluations

of all individuals requiring restrictive interventions.

- c. Develop diagnostic practices, guided by current, generally accepted professional criteria, for reliably reaching the most accurate psychiatric diagnoses.
- d. 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.
- e. Develop a clinical formulation of each patient that integrates relevant elements of the patient's history, mental status examination, and response to current and past medications and other interventions, and that is used to prepare the patient's treatment plan.
- f. Ensure that the information gathered in the assessments and reassessments is used to justify and update diagnoses, and establish and perform further assessments for a differential diagnosis.
- g. Review and revise, as appropriate, psychiatric assessments of all patients, providing clinically justifiable current diagnoses for each patient, and removing all diagnoses that cannot be clinically justified. Modify treatment and medication regimens, as appropriate, considering factors such as the patient's response to treatment, significant developments in the patient's condition, and changing patient needs.
- h. Develop a monitoring instrument to ensure a systematic review of the quality and timeliness of all assessments according to established indicators, including an evaluation of initial evaluations, progress notes and transfer and discharge summaries, and require the physician peer review system to address the process and content of assessments and reassessments, identify individual and group trends, and provide corrective follow-up action.

2. Behavior Management Services

OSH should develop and implement an integrated treatment planning process consistent with generally accepted professional standards of care. More particularly, OSH should:

- a. Develop and implement policies and procedures regarding the development of individualized treatment plans consistent with generally accepted professional standards of care.
- b. Review and revise, as appropriate, each patient's treatment plan to ensure that it is current, individualized, strengths-based, outcome-driven, emanates from an integration of the individual disciplines' assessments of patients, and that goals and interventions are consistent with clinical assessments. Revise each patient's treatment plan if it is not effective.
- c. Ensure that treating psychiatrists verify, in a documented manner, that psychiatric and behavioral treatments are properly integrated.
- d. Require all clinical staff to complete successfully competency-based training on the development and implementation of individualized treatment plans, including skills needed in the development of clinical formulations, needs, goals and interventions as well as discharge criteria.
- e. Ensure that individualized treatment plans are implemented in a consistent manner in accordance with generally accepted professional practices.
- f. Ensure that the medical director timely reviews high-risk situations such as individuals requiring repeated use of seclusion and restraints.
- g. 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.

- h. 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.
- i. Develop and implement treatment goals that will establish an objective, measurable basis for evaluating patient progress.
- j. Develop and implement policies to ensure that patients who are dually diagnosed as mentally ill/developmental disabilities or mentally ill/substance abuse, and patients with behavioral problems, are appropriately evaluated, treated, and monitored in accordance with generally accepted professional standards.
- k. For patients identified as suicidal, develop and implement a clear and uniform policy for patient assessment and treatment.
- l. Ensure that staff receive adequate training to serve the needs of patients requiring specialized care.

3. Medication Management and Monitoring

OSH should provide adequate psychiatric supports and services for the treatment of its patients, including medication management and monitoring of medication side-effects in accordance with generally accepted professional standards. More particularly, OSH should:

- a. Develop and implement policies and procedures requiring clinicians to document their analyses of the benefits and risks of chosen treatment interventions.
- b. Ensure that the treatment plans at OSH include a psychopharmacological plan of care that includes information on purpose of treatment, type of medication, rationale for its use, target behaviors, and possible side effects. Reassess the diagnosis in those cases that fail to respond to repeat drug trials.

- c. Ensure that individuals in need are provided with behavioral interventions and plans with proper integration of psychiatric and behavioral modalities. In this regard, OSH should:
 - i. Ensure that psychiatrists review all proposed behavioral plans to determine that they are compatible with psychiatric formulations of the case;
 - ii. Ensure regular exchange of data between the psychiatrist and the psychologist and use such exchange to distinguish psychiatric symptoms that require drug treatments from behaviors that require behavioral therapies; and
 - iii. Integrate psychiatric and behavioral treatments in those cases where behaviors and psychiatric symptoms overlap.
- d. Ensure that all psychotropic medications are:
 - i. prescribed in therapeutic amounts;
 - ii. tailored to each patient's individual symptoms;
 - iii. monitored for efficacy against clearly-identified target variables and time frames;
 - iv. modified based on clinical rationales; and
 - v. properly documented.
- e. Ensure that the psychiatric progress note documentation includes:
 - i. the rationale for the choice and continued use of drug treatments;
 - ii. individuals' histories and previous responses to treatments;
 - iii. careful review and critical assessment of the use of PRN medications and the use of this information in timely and appropriate adjustment of regular drug treatment; and

- iv. justification of polypharmacy in accordance with generally accepted professional standards.

- f. Institute systematic monitoring mechanisms regarding medication use throughout the facility. In this regard, OSH should:
 - i. Develop, implement and continually update a complete set of medication guidelines that address the indications, contraindications, screening procedures, dose requirements and expected individual outcomes for all psychiatric medications in the formulary that reflects generally accepted professional standards;

 - ii. Develop and implement a procedure for the identification, reporting and monitoring of adverse drug reactions (ADRs) that includes the definition of an ADR, likely causes, a probability scale, a severity scale, interventions and outcomes and that establishes thresholds to identify serious reactions;

 - iii. Develop and implement an effective Medication Variance Reporting system that captures both potential and actual variances in the prescription, transcription, procurement/ordering, dispensing/storage, administration and documentation of medications, and identifies critical breakdown points and contributing factors; and

 - iv. Develop and implement a procedure governing the use of PRN medications that includes requirements for specific identification of the behaviors that result in PRN administration of medications, a time limit on PRN uses, documented rationale for the use of more than one medication on a PRN basis, and physician documentation to ensure timely critical review of the individual's response to PRN treatments and reevaluation of regular treatments as a result of PRN uses.

C. Seclusion and Restraints

OSH should ensure that seclusion and restraints are used in accordance with generally accepted professional standards. Absent exigent circumstances -- i.e., when a patient poses an imminent risk of injury to himself or a third party -- any device 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 particularly, OSH should:

1. Eliminate the use of planned seclusion and planned restraint.
2. Eliminate standing orders for restraints and seclusion.
3. Eliminate prone restraints.
4. Ensure that restraints and seclusion:
 - a. Are used only when persons pose an immediate threat to themselves or others and after a hierarchy of less restrictive measures has been exhausted;
 - b. Are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;
 - c. Are not used as part of a behavioral intervention;
 - d. Are terminated as soon as the person is no longer an imminent danger to himself or others; and
 - e. Are used in a reliably documented manner.
5. Create or revise, as appropriate, and implement policies and procedures consistent with generally accepted professional standards that cover the following areas:
 - a. The range of restrictive alternatives available to staff and a clear definition of each; and

- b. The training that all staff receive in the management of the patient crisis cycle, the use of restrictive measures, and the use of less-restrictive interventions.
6. Ensure that if seclusion and/or restraint are initiated, the patient is assessed within an appropriate period of time and an appropriately trained staff member makes a determination of the need for continued seclusion and/or restraint.
7. Ensure that a physician's order for seclusion and/or restraint include:
 - a. The specific behaviors requiring the procedure;
 - b. The maximum duration of the order; and
 - c. Behavioral criteria for release, which, if met, require the patient's release even if the maximum duration of the initiating order has not expired.
8. Ensure that the patient's attending physician be promptly consulted regarding the restrictive intervention.
9. Ensure that at least every thirty minutes, patients in seclusion and/or restraint be re-informed of the behavioral criteria for their release from the restrictive intervention.
10. Ensure that immediately following a patient being placed in seclusion and/or restraint, the patient's treatment team reviews the incident, and the attending physician documents the review and the reasons for or against change in the patient's current pharmacological, behavioral, or psychosocial treatment.
11. Comply with 42 C.F.R. § 483.360(f) as to assessments by a physician or licensed medical professional of any resident placed in seclusion and/or restraints.
12. Ensure that staff successfully complete competency-based training regarding implementation of seclusion and restraint policies and the use of less-restrictive interventions.

D. Nursing Care

OSH should provide nursing services to its patients consistent with generally accepted professional standards. Such services should result in OSH patients receiving individualized services, supports, and therapeutic interventions, consistent with their treatment plans. More particularly, OSH should:

1. Ensure sufficient nursing staff to provide nursing care and services in accordance with generally accepted professional standards.
2. Ensure that, before they work directly with patients, all nursing staff have completed successfully competency-based training regarding mental health diagnoses, related symptoms, psychotropic medications, identification of side effects of psychotropic medications, monitoring of symptoms and target variables, and documenting and reporting of the patient's status.
3. Ensure that nursing staff monitor, document, and report accurately and routinely, patients' symptoms and target variables in a manner that enables treatment teams to assess the patient's status and to modify, as appropriate, the treatment plan.
4. Ensure that nursing staff actively participate in the treatment team process and provide feedback on patients' responses, or lack thereof, to medication and behavioral interventions.
5. Ensure that nursing staff document properly and monitor accurately the administration of medications.
6. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication have completed successfully competency-based training on the completion of the Medication Administration Records.
7. Ensure that all failures to properly sign the Medication Administration Record are treated as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.

8. Ensure that each patient's treatment plan identifies:
 - a. The diagnoses, treatments, and interventions that nursing and other staff are to implement;
 - b. The related symptoms and target variables to be monitored by nursing and other unit staff; and
 - c. The frequency by which staff need to monitor such symptoms.

9. Establish an effective infection control program to prevent the spread of infections or communicable diseases. More specifically, OSH should:
 - a. Actively collect data with regard to infections and communicable diseases;
 - b. Assess these data for trends;
 - c. Initiate inquiries regarding problematic trends;
 - d. Identify necessary corrective action;
 - e. Monitor to ensure that appropriate remedies are achieved;
 - f. Integrate this information into OSH's quality assurance review; and
 - g. Ensure that nursing staff implement the infection control program.

E. Discharge Planning

Within the limitations of court-imposed confinement and public safety, the State should actively pursue the appropriate discharge of patients and ensure that patients receive services in the most integrated, appropriate setting that is consistent with their needs. More particularly, OSH should:

1. Identify at admission and address in treatment planning the criteria that likely will foster viable discharge for a particular patient, including but not limited to:
 - a. The individual patient's symptoms of mental illness or psychiatric distress;

- b. Any other barriers preventing that specific patient from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and
 - c. The patient's strengths, preferences, and personal goals.
- 2. Include in treatment interventions the development of skills necessary to live in the setting in which the patient will be placed, and otherwise prepare the patient for his or her new living environment.
- 3. Provide the patient adequate assistance in transitioning to the new setting.
- 4. 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.
- 5. Ensure that the patient is an active participant in the placement process.
- 6. Contract with community providers on a "no rejection" basis or implement a state-operated system of community residential services.
- 7. Create or revise, as appropriate, and implement a quality assurance or utilization review process to oversee the discharge process and aftercare services, including:
 - a. Developing a system of follow-up with community placements to determine if discharged patients are receiving the care that was prescribed for them at discharge; and
 - b. Hiring sufficient staff to implement these minimum remedial measures with respect to discharge planning.

IV. CONCLUSION

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding OSH. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations -- which are not public documents -- under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them. We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with the State and are confident that we will be able to do so. The DOJ lawyers assigned to this investigation will be contacting the State's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

cc: The Honorable Hardy Myers
Attorney General
State of Oregon

David Freed, Ph.D
Interim Superintendent
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