T. 5-21-92

JRD:AEP:MHN:RF:VH:JAV:drb
DJ 168-52-16

PLGRIM

JUN 09 1992

REGISTERED MAIL
RETURN RECEIPT REQUESTED

The Honorable Mario M. Cuomo
Governor
State of New York
State Capitol Building
Executive Chamber
Albany, New York 12224

Re: Findings Letter Regarding Investigation of Pilgrim Psychiatric Center

Dear Governor Cuomo:

I am writing in reference to our investigation of the Pilgrim Psychiatric Center (Pilgrim), in Suffolk County, New York, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §§1997 et seq. While I am pleased to advise you that State officials are proceeding to implement agreed upon fire safety improvements at Pilgrim, recent investigatory activities undertaken in response to widespread allegations of deteriorating conditions at the facility have identified serious deficiencies regarding the provision of patient care. Consistent with the requirements of CRIPA, the purpose of this letter is to advise you of our findings by identifying the conditions at Pilgrim that deprive patients of their constitutional rights, the facts supporting our determination of constitutional violations, and the necessary remedial measures to correct these violations.

Conditions at Pilgrim

Based upon our extensive investigation, we have concluded that the following conditions at Pilgrim violate the constitutional rights of patients:

1) Inadequate protection of Pilgrim patients from injury and undue risks of harm;

2) Inadequate development, implementation, and monitoring of patient treatment plans and programs, including behavior programs;

cc: Records Chrono Peabody Nelson Frohboese Hughes Yost Hold

3) Dangerous or inappropriate medication practices, including the use of chemical restraints in lieu of treatment programs;

4) Inadequate medical care; and

5) Inadequate staffing, including psychiatrists, psychologists, registered nurses, therapists, and direct care staff.

We have concluded that Pilgrim patients are being subjected to egregious or flagrant conditions that deprive them of their constitutional rights pursuant to a pattern and practice of resistance to the full enjoyment of those rights. Specifically, we have concluded that these conditions at Pilgrim deprive patients of their constitutional rights to adequate medical care, reasonable safety, and such treatment programs as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily or chemical restraints. See Youngberg v. Romeo, 457 U.S. 307, 324 (1982). Each of the conditions or practices identified in this letter as being deficient represents a substantial departure from generally accepted professional judgment or is inconsistent with commonly accepted psychiatric and medical standards. The facts supporting our findings regarding these constitutional violations are set forth in the Attachment accompanying this letter.

Minimally Necessary Remedies

To eliminate the violations identified above and to ensure that constitutionally adequate conditions are maintained in the future, at a minimum, the State must implement the following remedial measures at Pilgrim:

1. Take immediate steps to adequately protect patients from injury and undue risks of harm, including increasing supervision by staff who are familiar with the needs of the patients for whom they are responsible and who are knowledgeable about appropriate interventions for agitated and assaultive patients. In addition, Pilgrim must take immediate steps to eliminate safety hazards that contribute to patient falls.

2. Hire and deploy sufficient qualified staff, including psychiatrists, registered nurses, psychologists, therapists, and direct care staff to ensure that patients are adequately supervised and receive appropriate mental health services.

3. Develop and implement professionally designed treatment programs, including behavioral programs for patients who need them;

4. Implement recordkeeping practices sufficient to ensure that professional judgment can be exercised regarding all aspects of patient care;

5. Revise medication practices to reflect generally accepted medical and psychiatric standards;

6. Cease using chemical restraints in lieu of adequate treatment programs;

7. Implement medical care practices that ensure adequate diagnosis and follow-up of the acute and chronic health care needs of patients;

8. Respond to the specialized needs of elderly patients by: (a) ensuring that staff implement current practices of care in geriatrics; and (b) implementing adequate prevention programs to decrease morbidity, mortality, and the risk of harm to patients who are susceptible to falling by assessing and addressing underlying physiological risks.

We appreciate the cooperation extended to us thus far during our CRIPA investigation by the Executive Director and the staff of the Pilgrim Psychiatric Center, officials of the New York Department of Mental Health, and counsel for the State. We hope that the cooperative spirit which has existed between the Department and the State will continue. My staff will be in contact with the Attorney General's office shortly to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding this matter, please contact Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255. I hope and trust that we will be able to resolve this matter in an amicable and reasonable manner.

Sincerely,

John R. Dunne
Assistant Attorney General
Civil Rights Division

Enclosures

cc: The Honorable Robert Abrams
Attorney General
State of New York

Andrew J. Maloney, Esquire
United States Attorney

Dr. Richard C. Surles
Commissioner
New York State Office of Mental Health

Ms. Peggy O'Neil
Executive Director
Pilgrim Psychiatric Center

Mr. Anthony Tirone
Director
Office of Survey and Certification

ATTACHMENT

Facts Supporting Findings of Constitutional Violations at Pilgrim Psychiatric Center

The Department's investigation of Pilgrim Psychiatric Center, initiated on September 30, 1987, has consisted of a series of tours of Pilgrim with a variety of expert consultants accompanied by our attorneys.

On January 29, 1990, we met with representatives of the State of New York to discuss fire safety deficiencies at various New York psychiatric facilities, including Pilgrim. During this meeting, we advised state officials that we accepted the State's plan to remedy significant fire safety deficiencies at Pilgrim as well as three other psychiatric facilities. Thereafter, we monitored progress in implementing this plan at Pilgrim and continued to investigate other areas.

In response to widely reported allegations that conditions of confinement at Pilgrim had seriously deteriorated, we most recently conducted tours of the facility during November 1991 and March and April 1992 with a psychiatrist, a psychologist, a psychiatric registered nurse, a geriatrician, and a fire safety expert. These tours included: 1) observations of conditions at Pilgrim; 2) interviews with Pilgrim administrators, staff, and patients; 3) review of a large number of patient records; and 4) examination and analysis of numerous other documents, including facility incident reports and analyses, committee meeting minutes, mortality reviews, staffing patterns, and policies and procedures.

The facts disclosed during these most recent tours supporting the Department's findings are set forth below.

I. Failure to Protect Patients from Harm

Due in large part to staffing shortages, Pilgrim has not and cannot ensure the safety of its patients from injury and unreasonable risks of harm resulting either from the effects of their own serious illnesses or from injuries inflicted by other patients. Our review of Pilgrim records showed a high rate of patient injuries occurring from acts of aggression and other events. During the last quarter of 1991, the rate of patient abuse, self-abuse, assaults, accidental injury, unauthorized leaves and escapes, as well as the overall incident rate at Pilgrim, were well above the facility's rates for the fourth quarter of 1990 and 1989. Significantly, the rate of patient assaults was considerably higher than it has been at any point during the past two years.

The harm reflected in Pilgrim's incident statistics is serious and often life-threatening. Patients are suffering countless fractures of their limbs, ribs, noses, and skulls,

lacerations requiring sutures, burns, and other injuries requiring emergency treatment. Pilgrim's Incident Review Committee has repeatedly concluded that closer staff supervision is necessary, particularly of frail and elderly patients. A review of Pilgrim records indicates significant numbers of serious injuries to patients and demonstrates Pilgrim's failure to provide a safe environment in contravention of their basic right to protection from harm.

There are also a number of elderly patients who fall and suffer fractures or lacerations requiring sutures. Pilgrim is failing to take sufficient steps to protect these patients through adequate staffing and necessary safety precautions. For example, we observed geriatric patients wearing ill fitting shoes or socks without shoes, thus increasing their susceptibility to falling.

In sum, injuries are occurring because there are too few staff to adequately observe and supervise patients and to eliminate safety hazards. Adding to this problem is the lack of sufficient staff to provide treatment programs and other essential mental health services. Without necessary treatment programs and other services, patients are left idle with the inevitable result that aggression, and related injuries, increase.

II. Inadequate Assessment and Development, Implementation, and Monitoring of Treatment Plans and Programs

There are major deficiencies at Pilgrim in the development and implementation of patient treatment programs. Adequate assessment and diagnosis, which are crucial to the formulation of an appropriate treatment plan, are often missing from patient evaluations. In some cases, diagnoses have been abruptly changed with no rationale reflected in the patient's record. In addition, numerous patient charts list symptoms that are either inconsistent with the patient's assigned psychiatric diagnosis or list symptoms that are not addressed by the diagnosis. In other cases, psychiatrists fail to identify an obvious secondary diagnosis, such as organic brain syndrome or substance abuse. Moreover, there is a widespread failure to include adequate psychological and nursing assessments in formulating patient diagnoses.

Treatment plans, themselves, fail to meet generally accepted professional standards for such plans. Indeed, plans reviewed at Pilgrim substantially depart from such standards. The plans do not reflect an inter-disciplinary approach by involving the appropriate professional disciplines, especially necessary involvement by nursing and psychological disciplines. As recognized by Pilgrim, medical needs are also often not incorporated into the treatment plan. Additionally, treatment

plans frequently do not address significant and obvious patient problems, are not individualized and relevant to patient needs, and contain treatment strategies so deficient as to be meaningless. For example, psychiatric interventions often consist primarily of the rote phrase that the patient should "take medications as prescribed." Procedures and practices regarding the review, monitoring, and revision of treatment plans are likewise inadequate.

Treatment programs which are developed for patients also fail to meet generally accepted professional standards. Implementation of even these programs has been inadequate to prevent deterioration and regression. While the new Rehabilitation Center that Pilgrim plans to open soon will provide opportunities for increased off-ward activities and programs, significant professional enhancement of treatment programs will be necessary. There is also a critical lack of any behavioral programming at Pilgrim. Many patients, especially those who are both mentally retarded and mentally ill and who have self-injurious, aggressive, or pica (the ingestion of non-edible substances) behaviors, need specific behavioral programs. Pilgrim, however, fails to provide them.

Overall, our consultants concluded that treatment plans and programs at Pilgrim are so deficient that long term hospitalization with resulting regression is the only prognosis for many patients.

III. Inappropriate Medication Practices

Medication practices at Pilgrim represent substantial departures from accepted professional judgment. The problems noted above in formulating proper diagnoses lead to inappropriate medication choices. Proper medication practices are per se not possible where the underlying diagnosis, the foundation of the entire treatment scheme, is not accurate or reliable. Even where accurate diagnoses may exist, our consultant observed that prescribed medications often do not correspond to the diagnoses. Some medications are given in doses exceeding professionally justifiable levels or absent professional justification. For instance, our consultants found that Pilgrim physicians are prescribing large amounts of inappropriate drugs for patient agitation and restlessness. Based on Pilgrim's data on patient medication regimens, our consulting psychiatrist concluded that too many patients are on large amounts of neuroleptics, the most potent form of psychotropic medications. He further found that Pilgrim physicians tend to start patients on large doses and when they convert patients to other medications, they switch from one large dose to another. In some instances, patients are continued on medications for years without any evidence of the medication's utility. In other instances, clinical trials of medications are far too short to determine the efficacy of the medications.

Patient chart reviews also revealed medications being changed without any written justification and without adherence to professional standards.

Due to long-term usage of neuroleptics, a number of Pilgrim patients have tardive dyskinesia, an irreversible neurological syndrome resulting in involuntary and sometimes incapacitating movements of the body. This condition is not being consistently charted or addressed in patient treatment plans by Pilgrim physicians. Not identifying, charting, or planning treatment for tardive dyskinesia represents a substantial departure from accepted practice and subjects Pilgrim patients to harm.

General recordkeeping deficiencies at Pilgrim also directly contribute to the poor medication practices found by our consultants. Recordkeeping that reflects the efficacy of medications through charting a patient's progress, or lack thereof, and sets forth the reason for medication decisions is necessary for a professionally based medication system; yet Pilgrim's recordkeeping practices fail to meet such a standard.

While mechanical restraint usage is relatively low at Pilgrim and camisole and other forms of mechanical restraints have recently been eliminated at the facility, patients are being chemically restrained by immediate ("stat") orders of a variety of medications which unduly impair the cognitive ability of patients. These medications are frequently ordered as a means to sedate agitated or unruly patients during nights and weekends, when staffing is at its lowest, to compensate for an inadequate number of personnel. Our psychiatric consultant found that stat chemical restraints are often ordered over the phone by an on-call physician. He further found that different on-call physicians frequently prescribe stat orders of varying psychotropic medications on successive days for the same patient. Moreover, there is often no follow-up by either the ordering physicians or nurse on duty, who frequently fail to record patient reactions to these stat medications. In one such instance, a patient was found dead the morning after a telephone stat order for a psychotropic medication. While the precise role the administration of the stat order played, if any, in the death of this patient cannot be determined, it is significant to note that there were no progress notes in the patient's record documenting the effect of the medication. In addition, there were no monthly medical notes in this patient's record for the five months preceding her death. Pilgrim's practices with regard to stat orders of medications, particularly anti-anxiety medications, are dangerous, depart substantially from accepted professional standards, and constitute undue use of restraints.

In sum, the lack of adequate medication practices at Pilgrim violates the constitutional rights of patients by exposing them to dangerous medications without appropriate justification and by denying them appropriate medical intervention which leads to continuing harmful conditions, deterioration, and inappropriate chemical restraint of patients.

IV. Inadequate Medical Care

Based upon our review of patient records at Pilgrim, particularly those records of patients who either died or were transferred to other hospitals for acute medical care, it is evident that there are deficiencies in responding adequately to acute and chronic illnesses. Many of these deficiencies persist despite having been identified by Pilgrim as problematic through peer review, quality assurance activities, or mortality reviews. For instance, physicians are failing to order necessary diagnostic tests in response to serious illnesses. In other situations, there is a failure on the part of the physician to follow up on abnormal test results by providing prompt clinical action. There are problems, as well, in the accuracy and timeliness of diagnostic tests, particularly initial readings of x-rays. In addition, Pilgrim physicians are failing to provide consultants and acute care hospitals to which Pilgrim patients are temporarily transferred with sufficient background information about the patient to enable appropriate treatment. Further, in several recent cases involving patient deaths, Pilgrim's Mortality Review Committee has cited physician failure to take expedited action in emergency situations where patients are critically ill.

Medical care for geriatric patients at Pilgrim is particularly inadequate. As of April 1992, 637 Pilgrim patients, or more than 40% of the facility's total population, ranged in age from 65 to 105. Pilgrim does not have a geriatric psychiatrist or geriatrician on its staff and its current complement of ward psychiatrists and physicians lack the experience and training to provide adequate treatment to meet the complex psychiatric and health care needs of Pilgrim's elderly patients, most of whom have multiple physical and mental health problems. Our consultant in geriatrics concluded that the medical care Pilgrim is providing to its geriatric patients does not comport with accepted professional standards of care in geriatric medicine. In fact, our expert described the level of medical care for geriatric patients at Pilgrim to be at least ten years behind current practices.

The lack of expertise at Pilgrim in the specialized needs of geriatric patients is evident in a number of areas. For example, our geriatric consultant found cases where physicians treated agitated elderly patients with sedatives or tranquilizers instead of conducting a full medical assessment of the underlying cause

of the agitation. This is particularly important given that agitation in geriatric patients can be a non-specific manifestation of a variety of illnesses. In addition, medical care of geriatric patients at Pilgrim lacks an adequate focus on prevention of morbidity. For example, Pilgrim fails to provide geriatric patients with a vaccine for pneumonia, as required by generally accepted professional standards of care.

Further, as noted earlier, there is a high rate of elderly patients who fall and suffer fractures or lacerations requiring sutures. Although Pilgrim has created a Fracture Review Committee, the facility is not taking a sufficiently aggressive approach to address this problem. For instance, an assessment tool to guide the physician's analysis of reasons why a patient has fallen has been in draft form for the past year. In the meantime, physicians are failing to take basic diagnostic and preventive steps to prevent falls. For example, physicians are not routinely reviewing medication regimens and measuring orthostatic hypotension, a basic diagnostic procedure measuring blood pressure, in patients who fall. In addition, physicians are prescribing inappropriate drugs for elderly patients, which has resulted in instances of serious falls. Moreover, as acknowledged by Pilgrim staff in record reviews, physicians have failed to conduct neurological exams and to adequately review incidents of trauma when patients fall or are injured.

In sum, medical care at Pilgrim fails to meet constitutional standards.

VI. Inadequate Staffing

Pilgrim does not have a sufficient number of psychiatrists, psychologists, nurses, therapists, and direct care staff (mental health therapy aides - "MHTA's") to provide sufficient supervision and adequate mental health services to its patients. We were advised by Pilgrim administrators that staff has been significantly reduced during the past year. Lack of adequate staff is responsible for many of the deficiencies at Pilgrim, identified here. Pilgrim is unable to implement needed remedial measures because it lacks adequate resources to accomplish them.

The number of mental health therapy aides currently assigned to wards at Pilgrim is insufficient to provide adequate patient supervision, to protect patients from harm, and to implement treatment plans. During February 1992, direct care staff were frequently responsible for up to 17 patients on a ward. These staff-to-patient ratios are too low to ensure patients' safety, much less provide patients with needed treatment for their disabilities.

Further, Pilgrim is acutely understaffed in registered nurses who provide direct patient care. The shortage of registered nursing staff is most serious on nights and weekends. For example, our nursing consultant noted that during November 1991, one registered nurse was often assigned to cover an entire building on nights or weekends. Although the nursing ratios improved somewhat during 1992 due to downsizing and ward consolidation, nursing coverage remains inadequate. It is not uncommon to find one nurse responsible for three wards of up to 100 patients during weekends. In fact, in one building during a two week span in February 1992, one nurse was responsible for three wards nearly 50% of the time. As recently as April 1992, two nurses were responsible for 263 patients during the night shift. During our April 1992 tour, Pilgrim's Director of Nurses indicated that seven new nurses had been hired and funds had been allocated to hire twenty-five additional nurses. Even with these planned additions, however, there will be an insufficient number of nurses to meet significant patient needs.

Pilgrim also has an inadequate number of psychiatrists to provide necessary mental health services. Because of the lack of psychiatrists, it is common for a psychiatrist to have a caseload of 60 or more patients. We were also informed by Pilgrim staff that the State does not intend to replace any psychiatrists who leave the facility or retire. It is simply impossible to provide adequate and appropriate psychiatric care to the large number of patients for whom Pilgrim psychiatrists are responsible, especially given the fact that the Pilgrim clinical staff acknowledge that their patients have multiple, complex psychiatric problems that must be addressed. Although Pilgrim has an arrangement with Mt. Sinai Hospital to provide psychiatric consultation for patients with specialized needs, funding has been inadequate to support this program.

Finally, there are an insufficient number of psychologists and therapists to develop and implement necessary treatment programs, including behavioral programs, required by Pilgrim patients. These staffing deficiencies result in inadequate programs.

Overall, Pilgrim's deficiencies in professional and direct care staffing pose serious risks to patients' safety and well-being and impede appropriate treatment of their mental disabilities.

Additional Recommendation Regarding Fire Safety Renovations at Pilgrim Psychiatric Center

While each of our monitoring tours of Pilgrim has identified significant progress in the implementation of the State's overall plan to remedy fire safety deficiencies, our most recent tour disclosed several deficiencies which our consultant recommends should be addressed as soon as possible. Our consultant noted the absence of required door closing mechanisms and various doors in a state of significant disrepair. Moreover, he noted combustible materials stored in areas which were not adequately separated from egress routes. As the State continues to implement its overall plan for major renovations to remedy fire safety deficiencies at Pilgrim, it should address the type of maintenance deficiencies that our consultant identified during his most recent tour.