JPT:AEP:MHN:VH:RF:CA:drb
DJ 168-21-10

MAR 1 1990

BY OVERNIGHT AND
REGISTERED MAIL
RETURN RECEIPT REQUESTED

Honorable John Waihee
Governor of Hawaii
Hawaii State Capitol
Honolulu, HI 96813

Re: Notice of Findings Regarding Hawaii State Hospital, Kaneohe and Honolulu, Hawaii, 42 U.S.C. §1997b(a)(1)

Dear Governor Waihee:

On November 6, 1989, we informed you that, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §1997, we were commencing an investigation into conditions at Hawaii State Hospital (HSH), in Kaneohe and Honolulu, Hawaii. On December 11-14, 1989, attorneys and consultants from the Department of Justice toured HSH. Our touring team examined patient records, interviewed the facility superintendent and numerous staff and spoke with patients. We also reviewed numerous documents provided by the facility concerning a wide range of procedures and activities. During the investigation, our people were treated graciously by HSH staff and attorneys from the Hawaii Attorney General's office.

On the basis of our investigation we have concluded that HSH subjects patients to conditions that deprive them of certain of their constitutional rights. Institutionalized mentally ill persons are constitutionally entitled to adequate food, clothing, shelter, medical and nursing care, a reasonably safe environment and such treatment programs as an appropriate professional would consider reasonable to ensure a patient's safety and freedom from undue bodily and chemical restraint. Cf. Youngberg v. Romeo, 457 U.S. 307, 324 (1982). Set forth below are those conditions which violate the constitutional rights of HSH patients.

cc: Records Chrono Peabody Nelson Frohboese Hughes Alford Hold

Hawaii State Hospital at Kaneohe

1. Inadequate Food, Clothing, and Shelter

Our investigation disclosed that HSH fails to afford its patients basic elements of life's necessities. Specifically, patients are not provided adequate amounts of food, sufficient clothing, essential personal hygiene supplies, and an environment which is free from unreasonable risks to their personal health and safety.

The amount of food served to patients is highly questionable in terms of nutritional adequacy. Staff on the Pali Unit advised our consultants that the amount of food available to serve patients was consistently inadequate. Specific reference was made to the unavailability of adequate food for newly admitted patients. Finally, food served to outlying units is transported and served in styrofoam food containers. This method of food distribution presents a serious health risk because the containers do not keep the food sufficiently hot or cold from the time it is put into the containers in the central kitchen until actually served to patients on the various living units.

There is also inadequate clean clothing and essential personal hygiene materials at HSH for use by patients. Staff reported that patients are often wrapped in blankets or sheets due to the absence of adequate clothing. Our consultants observed what appeared to be communal use of soap, shampoo, and toothbrushes due to the lack of adequate personal hygiene items. The communal use of such personal hygiene materials represents an unreasonable risk to the health of residents since germs and bacteria are easily passed in this manner. Moreover, staff indicated that there were shortages of towels, clean linens and other items necessary to employ basic personal hygiene measures.

While we were apprised of plans to build new hospital facilities to house a substantial number of HSH patients, the environment at the present facility is so inadequate that living conditions pose serious risks to the health and safety of patients. While the plan to close many current buildings and replace them with new facilities is commendable, new construction will not necessarily solve all of the environmental problems identified below. Indeed, new facilities will be of little assistance to forensic and adolescent patients who will continue to be housed in their current buildings.

First, the facility is dangerous. Suicide hazards abound throughout the facility. Exposed metal pipes, electrical cords wrapped loosely around ceiling fans, non-bendable and non-breakable curtain rods, and exposed containers of cleaning fluids

and other hazardous materials are ubiquitous throughout the facility. Seclusion rooms are especially dangerous. Such rooms have blind spots, holes in their walls, exposed jagged edges, peeling paint and protruding nails. Beds are kept in seclusion rooms with restraint straps attached. These conditions pose serious risks to suicide prone patients. Due to crowding on the Pali Patio Unit, two beds are placed in rooms built to house only one, leaving only a few inches of space between beds used to serve newly admitted acutely psychotic patients. Moreover, since the beds are not bolted to the floors, staff advised our consultants that patients frequently use the beds to barricade themselves inside the room, requiring staff to break down the door to gain access. Finally, the facility contains numerous fire hazards, including inadequate fire evacuation routes, insufficient smoke compartmentalization, and lack of sprinklers.

Second, sanitation is grossly inadequate. During a tour of the Rehab A unit of HSH, our consultants had to walk around numerous puddles of urine. Staff appeared to treat the incident as not atypical and it was a significant length of time before the area was cleaned. Kitchen facilities exhibited signs of serious cockroach infestation and other unsanitary practices. Basic and fundamental infection control procedures were consistently violated at the facility.

Third, the facility is poorly maintained. Our consultants were in universal agreement that the facility was poorly maintained and in a general state of disrepair and dilapidation. Indeed, our consultant psychologist opined that the current environment at HSH is, in brief, "unsafe;" our consultant psychiatrist described HSH, in a word, as an "abomination."

In sum, the lack of adequate food, clothing, basic personal hygiene measures, and an environment free from unreasonable risks to the personal safety of patients violates their constitutional rights. The lack of adequate food and clothing are especially flagrant or egregious conditions requiring immediate correction.

2. Unsafe Psychopharmacological Practices

It is our consultant psychiatrist's opinion that drug practices at HSH are seriously deficient and represent significant departures from generally accepted medical standards. There are essentially no policies and procedures in effect at the hospital for the use of psychotropic medications. There are no policies with respect to monitoring maximal dosage, polypharmacy, dosage schedule, dosage form, or laboratory requirements. The absence of policies and procedures in these areas represents so great a departure from accepted medical judgment as to demonstrate that professional judgment was not, in fact, exercised in the provision of care to institutionalized mentally ill persons.

Many patients at HSH are administered powerful, mind altering medications which exceed the recommended maximal dosage. The patient records we reviewed did not contain justifications for such dosage levels, nor were there indications in the records that physicians attempt to treat patients at the lowest effective dosage or that physicians are striving to wean patients off these drugs, as appropriate. Antipsychotic medication is being prescribed for patients without a psychotic condition and two or more medications of the same chemical class (polypharmacy) are routinely administered to hospital patients absent any justification. Specific drugs are being administered to patients absent a diagnosis which would warrant the use of such drugs. Since there is no policy regarding dosage schedule, patients are receiving medication at various inappropriate intervals with no rationale. Moreover, patients are receiving simultaneously, both oral and intramuscular depot forms of medication, again, absent any justification. Further, our consultant noted that routine but crucial laboratory tests were not being conducted for patients and that screening of patients for tardive dyskinesia is inadequate. Finally, and most significantly, our consultant psychiatrist noted the "remarkably ubiquitous use" of PRN or "as needed" medication. Such usage places the decision to medicate in the hands of nurses who do not have sufficient expertise to medicate patients and exposes patients to significant risks, including the risk of overmedication. To compound the problem at HSH, physician review, monitoring, and examination of patients receiving medications on this basis is inadequate.

These medication deficiencies are due, in part, to both an inadequate number of psychiatrists, registered nurses, and psychologists as well as the absence of any organizational structure at HSH which places responsibility for various clinical functions and individual patients in specifically designated persons. HSH does not have a permanent Clinical Director. As such, there is no one at HSH with the ultimate responsibility for the clinical care of patients. Moreover, the deficiencies caused by inadequate patient coverage by psychiatrists is exacerbated by the fact that psychiatrists attending patients are often retained from the community on a part-time, fee for service, basis. As administered at HSH, this system of providing psychiatric care to patients has proved inadequate and has harmed patients. Further, the number of registered nurses at HSH is grossly deficient; nearly 42% of all nursing positions at the hospital are currently vacant. One-half of the psychologist positions are also vacant. Such vacancies compromise the delivery of patient care, including the failure to monitor patients for the effects of psychotropic medication, inadequate basic and essential nursing services, and the failure to address the behavioral problems exhibited by many patients which are now addressed by the excessive use of physical and chemical restraint.

In sum, psychopharmacological practices at HSH are so deficient as to violate the constitutional rights of HSH patients by exposing them to unreasonable risks to their health and safety. Lack of adequate professional staff to prescribe and monitor the usage of the medications is largely responsible for the problem.

3. Inadequate General Medical Care

HSH operates no on-grounds infirmary for physically ill patients. As a result, general medical services are provided by off-grounds care providers. HSH medical staff informed us that the absence of adequate procedures to insure the timely transfer of physically ill patients to the community health care facility results in protracted delays in actually transferring patients to the community hospital, thereby placing patients in severe jeopardy. While the use of community resources is unobjectionable, there is no justification for the failure to ensure that patients are referred and transported to such services in a timely manner once facility professionals have determined the need to provide services outside HSH.

Medical staff likewise advised us that the number of on-grounds physicians is inadequate to care for the medical care needs of patients who do not, or cannot, receive medical services outside HSH. The shortage of medical staff at the facility results in inadequate monitoring of sick patients, and, in some instances, the failure to implement a physician's orders. Moreover, the current medical staff is inadequate to meet the medical needs of physically handicapped patients who present a host of specialized needs, including the need for individually adapted wheelchairs and other equipment requiring some degree of medical involvement. Finally, there is no physician of any kind at the facility at night and on weekends. It is unacceptable for a facility of the size and nature of HSH to function absent the presence of a physician on grounds at all times.

Medical care at HSH requires significant improvement to insure that HSH patients receive adequate medical care.

4. Lack of Adequate Treatment Programs Results in Undue Bodily Restraint

In view of serious, chronic and facility-wide staffing shortages, HSH staff employ bodily restraints -- physical restraints, seclusion, and chemical restraints -- at an unjustifiably high level solely for their own convenience or in lieu of professionally designed treatment programs. The use of bodily restraints at HSH currently exposes patients to unreasonable risks to their personal safety. Patients are routinely placed in seclusion rooms or physical restraint based on the telephone order of a physician. While these procedures

may be appropriate in an emergency where no doctor is readily available, there is no justification -- as is the practice at HSH -- for physicians to fail to examine the secluded patient within a reasonable period of time and for the patient to be monitored by professional staff at reasonable intervals. Moreover, staff were so unfamiliar with HSH rules and procedures for the placement of patients in bodily restraints that they almost universally were unable to state how long a specific restraint order could remain in effect before requiring renewal. This deficiency is especially severe because it means that patients are routinely left in bodily restraint, especially seclusion, for periods of time in excess of that necessary to restore them to a controlled state. Indeed, records reviewed indicated that many patients were secluded for periods of time far longer than that recognized by any known standard. In addition, direct care staff are not adequately trained to place patients in seclusion rooms or to administer other physical restraints. It is the view of our consultant psychiatrist that patients are routinely secluded and placed in physical restraints at HSH absent adequate justification and without proper documentation. In view of the absence of full documentation, it was his further view that it is impossible to determine precisely the exact amount of bodily restraint used at the hospital.

Treatment programs for patients at HSH exhibiting dangerous behaviors and other maladaptive behaviors exposing them to unreasonable risks of harm are inadequate. To the extent that "programs" have been developed for patients, they are not professionally based because the current psychology staff is inadequate to properly assess patient behavior, develop and monitor behavior management programs, and to revise them, as necessary. Moreover, the direct care staff is insufficient in number, is not trained, and is otherwise ill-equipped to implement the programs. Further, data is not maintained at the facility regarding patient behavior necessary to properly monitor and revise behavior management programs. The absence of behavior management programs subjects patients to undue bodily restraint and a wide array of unreasonable risks to their personal safety.

5. Inadequate Recordkeeping Practices

Our consultants found documentation at HSH to be grossly inadequate. Documentation is insufficient to permit staff to exercise professional judgment in the provision of patient care. As described above, documentation regarding the use of medication is deficient in all respects. Moreover, our review of patient records revealed that months go by without physicians making notes in patients records and that chronic patients seldom, if ever, see a psychiatrist. The lack of notes in patient records by these professionals and those associated with other disciplines regarding an individual's care and treatment leaves

professionals without basic information necessary for the exercise of professional judgment.

Children's Unit at Honolulu

Our investigation indicated many of the physical plant deficiencies existing at the Kaneohe facility likewise exist at the Children's Unit (Leahi A and B). Suicide hazards are present throughout the units; seclusion rooms are unsafe. Indeed, it was our psychologist consultant's opinion that the use of the "pink" seclusion room be halted immediately due to its especially hazardous condition for children. Finally, fire hazards are prevalent throughout.

Minimally Necessary Remedies

The conditions described above constitute a pattern and practice that results in deprivation of certain constitutional rights of Hawaii State Hospital patients. To eliminate these violations and to ensure that constitutionally adequate conditions are maintained in the future, the following minimum remedial measures are required:

1. HSH must immediately provide all patients with adequate clothing and essential personal hygiene items;

2. HSH must immediately provide patients with sufficient food that is nutritionally adequate and served in a manner that does not pose risks to patients' health;

3. Environmental, sanitation, infection control, and fire-safety deficiencies that pose a risk to patients' safety must be corrected immediately;

4. Improvements in medication practices, including medication monitoring, must be effected where necessary to conform practices to accepted medical standards;

5. HSH must ensure that patients have timely access to adequate medical care.

6. HSH must hire and deploy sufficient qualified direct care and professional staff, including psychiatrists, psychologists, physicians, and registered nurses, to ensure that patients receive adequate medical and psychiatric care, including treatment plans and behavior management plans and follow-up treatment sufficient to reduce or eliminate unreasonable risks of harm to their personal safety;

7. HSH must recruit and hire a permanent Clinical Director, and HSH's table of organization must be revised in order to establish clear lines of responsibility and authority between and among HSH staff;

8. Seclusion and restraint practices must be employed only pursuant to the exercise of professional judgment by a qualified professional. The practice of using seclusion and restraint for the convenience of staff or in lieu of treatment or training programs must cease immediately. Seclusion rooms must be modified to allow full vision of patients, leather straps must be removed when a patient is in seclusion and the rooms must be properly and safely maintained;

9. HSH must institute and implement recordkeeping practices sufficient to ensure treatment documentation adequate to enable staff to provide essential psychiatric, psychological and nursing care and treatment services to patients;

We would be pleased to consult with you regarding financial, technical, or other assistance which might be available from the United States to assist you in correcting the deficiencies described. You may wish to consult with the Department of Health and Human Services (HHS) to inquire about the possibility of assistance through programs it administers. Please contact Dean Dana, Regional Director, Department of Health and Human Services, Federal Office Building, 50 United Nations Plaza, San Francisco, California, 94102 (telephone 415-556-6746) for information regarding HHS programs.

We appreciate the cooperation extended to us during our CRIPA investigation by the superintendent and staff of Hawaii State Hospital, officials of the Hawaii Department of Mental Health, and counsel for the State.

We hope that a cooperative spirit will prevail so that this matter can be concluded promptly and amicably. Indeed, we hope and trust this information will assist you in developing appropriate remedies while the Hawaii legislature is in session. My staff will contact the Attorney General's office shortly to discuss this matter further. In the meantime, if you or your staff have any questions regarding this matter, please contact Arthur E. Peabody, Jr., Chief, Special Litigation Section, at

202-272-6060. I hope and trust that we will be able to resolve this matter in an amicable and reasonable manner.

Sincerely,

James P. Turner
Acting Assistant Attorney General
Civil Rights Division

cc: Honorable Warren Price
Attorney General
State of Hawaii

Dr. Howard Gudeman
Superintendent, Hawaii State Hospital

Daniel A. Bent, Esquire
United States Attorney