U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

U.S. v. Tennessee

MH-TN-001-003

February 6, 1992

REGISTERED MAIL
RETURN RECEIPT REQUESTED

Honorable Ned McWherter
Governor of Tennessee
State Capitol
Governor's Office
Nashville, TN 37243

Re: Findings Letter Regarding Memphis Mental Health Institute, Memphis, Tennessee

Dear Governor McWherter:

On December 12, 1990, we informed you that, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., we were commencing an investigation into conditions relating to patient care and treatment at the Memphis Mental Health Institute ("MMHI") in Memphis, Tennessee. As specified by CRIPA, we are now writing to inform you of our conclusions that the conditions at MMHI deprive patients there of their constitutional rights. We also outline the minimum measures we believe necessary to remedy those unconstitutional conditions. Finally, in the Attachment to this letter, we set forth the facts supporting the findings of constitutional violations.

Based on our extensive investigation, we conclude that conditions at MMHI deprive patients of their constitutional rights to adequate medical care and such treatment as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily and chemical restraints. Cf. Youngberg v. Romeo, 457 U.S. 307, 324 (1982).

As you will recall, on April 4, 1991, following our initial tours at MMHI, we informed you in writing that MMHI was subjecting its patients to grossly substandard psychiatric care and treatment caused, in significant part, by the failure to provide a sufficient number of staff, including psychiatrists, nurses and psychiatric technicians. In our letter, we specifically requested reconsideration of the State's decision to cut 24 staff positions at MMHI. By letter dated May 22, 1991, you responded to our findings by stating, among other things, that the State was studying this issue. No further response has been received. We subsequently learned that 24 staff positions at MMHI were cut. While we further understand that the unit covered by these 24 positions was ultimately closed, these cuts have exacerbated staffing shortages at the facility. The lack of a sufficient number of adequately trained staff contributes substantially to the unconstitutional conditions we find at MMHI.

We have identified the following conditions and practices which we believe violate the constitutional rights of MMHI patients:

1) Failure to provide patients with adequate general and emergency medical care;

2) Inadequate psychiatric care and medication practices including:

   a) Lack of psychiatric staff;

   b) Dangerous medication regimens; and

   c) Inadequate development and implementation of individualized treatment plans.

3) Improper and excessive use of physical restraints, including restraining patients in locked-door seclusion rooms without adequate supervision.

These deficiencies subject patients at MMHI to harm, both potential and real.

In order to eliminate the egregious or flagrant conditions that deprive MMHI residents of their constitutional rights, the following measures, at a minimum, must be implemented:

1) MMHI must hire and deploy a sufficient number of qualified direct care and professional staff, including psychiatrists, psychologists, registered nurses and psychiatric technicians, to ensure that patients receive adequate medical and psychiatric care, including the development and implementation of individualized patient treatment plans;

2) MMHI must institute improvements in its medication practices, including monitoring medications and medication interactions and side-effects, to remedy departures from accepted professional standards;

3) MMHI must improve its medical health care delivery system to ensure that patients have timely access to adequate emergency and general medical care;

4) Restraints must be employed only pursuant to the exercise of professional judgment by a qualified professional. The practice of using restraint for the convenience of staff or in lieu of adequate staffing or the implementation of treatment programs must cease immediately. The practice of restraining patients and then placing patients in a locked-door seclusion room must cease immediately. Patients must be released from seclusion as soon as their physical and mental condition will allow for safe release;

5) MMHI must institute recordkeeping practices that will ensure documentation sufficient to enable staff to render professional judgments as to medical, psychiatric, psychological and nursing treatment services; and

6) MMHI must immediately halt the practice of using untrained unit clerks as psychiatric technicians.

To remedy the deficiencies at MMHI and to ensure that constitutionally adequate conditions are maintained thereafter, we propose, as an amicable resolution of this matter and based upon the principles of conciliation and negotiation embodied in CRIPA, to negotiate an agreement with the State of Tennessee to be entered as an order of a federal court. Any such agreement shall provide, at a minimum, that the above referenced remedies be implemented at MMHI.

We suggest you contact the appropriate regional office of the Departments of Health and Human Services and the Department of Education to ensure that the State is maximizing its use of federal financial assistance -- assistance that may be utilized to correct the deficiencies identified in this letter.

Our attorneys will be contacting legal counsel for the Tennessee Department of Mental Health and Mental Retardation shortly to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding

this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255. We continue to hope and trust that this matter can be resolved in an amicable manner.

Sincerely,

John R. Dunne
Assistant Attorney General
Civil Rights Division

cc: Honorable Charles Burson
Attorney General
State of Tennessee

Mr. Evelyn C. Robertson, Jr.
Director
Department of Mental Health and
Mental Retardation

Mr. Walter Diggs
Superintendent
Memphis Mental Health Institute

Ed Bryant, Esq.
United States Attorney
Western District of Tennessee

Mr. Anthony Tirone
Director
Office of Survey and Certification
Health Care Financing Administration

ATTACHMENT

FACTS SUPPORTING FINDINGS OF CONSTITUTIONAL VIOLATIONS

Our investigation consisted of three separate tours of MMHI with four expert consultants: a psychiatrist, a psychiatric nurse, a psychologist, and a physician. We observed conditions on the various patient units, interviewed administrators, staff and patients and examined a variety of records concerning a wide range of facility operations. Throughout the investigation, we were treated graciously and received complete cooperation from the administrators and staff of MMHI and from attorneys of the Department of Mental Health and Retardation.

The following paragraphs set forth the facts supporting our findings.

1. Failure to provide patients with adequate general and emergency medical care and nursing care.

Major deficiencies exist in the medical care delivery system at MMHI, including the inability to recognize and treat life-threatening or dangerous medical conditions, deficient follow-up of recognized problems, inadequate physical examinations, including inadequate neurological examinations, deficient interpretations of abnormal laboratory findings, deficient formulation of medical treatment plans and deficient medical recordkeeping.

Many of the deficiencies in medical services can be traced directly to inadequate numbers of trained staff. Specifically, it is our consultant physician's opinion that MMHI staff are not adequately trained to recognize the serious medical needs of patients. As a result, patient ailments or illnesses can deteriorate to the point where such conditions become life threatening.

Deficiencies in the medical care service delivery system at MMHI have resulted in physical harm to MMHI patients. Our medical consultant believes such deficiencies may have contributed to the deaths of two MMHI patients. His review of these charts suggests that MMHI staff members failed to recognize the severity of these patients' worsening conditions prior to the time such conditions presented medical emergencies. Furthermore, various members of the nursing and medical staffs we interviewed were unfamiliar with "crash cart" emergency medical equipment. Some of MMHI's emergency equipment was also faulty.

MMHI's physicians are not proficient, trained or certified in advanced cardiac life support. In reviewing code blue calls for the previous six months, our consultant physician notes numerous examples of inadequate responses. In one instance, the code blue physician failed to arrive until 16 minutes after the code blue was called. In other instances, physicians failed to institute even the most basic life saving measures, such as the administration of oxygen or intravenous fluids, when the patient's condition required such treatment. It is our consultant's opinion that, in at least one instance, poor response to a code blue call contributed to a patient's death.

Significantly, while touring MMHI we observed staff participating in an unscheduled code blue exercise in which the hospital administrator played the role of a patient who had suffered a seizure and was aspirating. The MMHI response team made several serious mistakes. First, hospital operators announced the code blue as taking place on the wrong unit, resulting in a delay in the arrival of the code blue team. Second, the nursing staff who were instituting basic life support failed to take appropriate action to establish an adequate airway in the victim's throat. If the exercise had been a real emergency, the "victim" might have suffered serious brain damage or even death.

Resources and expertise to provide general medical care are likewise deficient. MMHI lacks a sufficient number of registered nurses to provide adequate, professional nursing care to patients. Current nurse staffing is inadequate to provide necessary patient assessments, treatment planning, supervision and evaluation of patients' conditions, including any untoward change in patients' conditions. Further, although MMHI does have in place a policy relating to severity of illness and assignment of staff accordingly, which includes adult service minimum safe staffing standards, MMHI was unable to meet its own recognized minimum safe standards for the several weeks before our consultant nurse's tour. Nurse staffing appears to be based on the number of positions approved by the State rather than on any system related to patient need.

The ratio of registered nursing to non-registered nursing patient care positions at MMHI (27% to 73%) is inadequate to provide for appropriate supervision of the non-licensed direct care staff. This ratio is an especially critical deficiency at MMHI given that psychiatric technicians (PTs) at MMHI are hired without any previous psychiatric background and often receive only "on the job" training. We find instances where psychiatric technicians are hired and assigned to patient wards without previous psychiatric experience and without receiving MMHI's own 120-hour PT training program. This is particularly dangerous given that inadequately trained staff are responsible for placing patients in restraints.

We also find that MMHI is using untrained ward clerks -- essentially clerical personnel -- as substitute PTs on night shifts. This practice must stop immediately because unit clerks have absolutely no training in providing psychiatric nursing care.

MMHI's policies and procedures regarding the identification, treatment and follow-up of active medical problems are inadequate. Moreover, MMHI's infectious disease/isolation practices are so deficient as to threaten the health and safety of MMHI patients. Our consultant finds practices in the areas of the prevention of hepatitis transmission, HIV precautions, tuberculosis screening, and immunization to be especially problematic.

In addition, neurologic exams performed by MMHI staff are grossly inadequate. Only the most basic and rudimentary exams are performed. There is no systematic evaluation for the extra-pyramidal side effects of psychotropic medications. It is our consultant's opinion that the neurological exams performed at MMHI represent a significant departure from accepted practice in that they provide neither an accurate assessment of neurological function nor an evaluation for medication side effects.

Medical recordkeeping at MMHI is also inadequate. Physicians' findings, assessments, and plans are not adequately documented. From a review of the records, it is often impossible to determine if a physician actually examines a given patient or merely observes the patient from a distance. There are also indications in patient records that suggest that physician and nursing notes are written at a later date, backdated, and inserted into the medical record without being clearly identified as such. While we do not, at the moment, ascribe any improper motive to these backdated records, such a practice is clearly not in keeping with accepted standards of practice.

2. Inadequate psychiatric care and medication practices.

a. Lack of psychiatric staff.

The lack of professional resources, including appropriate staffing, results in the failure to provide constitutionally adequate psychiatric care and treatment. Simply put, there are too few psychiatrists at MMHI to provide necessary care and treatment to patients. During the time of our psychiatrist's visit, there were only four psychiatrists providing service to approximately 170 patients. This psychiatrist-to-patient ratio is woefully inadequate -- especially in light of the severe psychiatric conditions of MMHI patients.

b. Dangerous medication regimens.

A major problem resulting from the shortage of psychiatrists at MMHI is that non-psychiatric trained physicians prescribe psychotropic medications and attempt to provide psychiatric care without adequate supervision by trained psychiatrists. As a result, many aspects of drug usage at MMHI represent substantial departures from generally accepted medical standards. For example, a review of records reveals numerous instances where patients are misdiagnosed or exposed to inappropriate dosages of drugs used in the treatment of mental illness and dangerous drug interactions. Other patients are subjected to both inappropriate drug combinations and physical restraint, or treated for psychiatric symptoms when their illnesses have organic origins. We also note patients who are started on abnormally large doses of potent medications without any justification in the patients' records. Deficiencies of this kind are aggravated by the inadequacy of MMHI's policies and practices pertaining to the monitoring of drug side effects. Adverse medication reactions are, by MMHI's admission, underreported.

c. Inadequate development and implementation of individualized treatment plans.

We find consistent evidence that MMHI patients are not receiving individualized treatment based on plans designed to meet specific patient needs. This is especially true of, and a critical deficiency for, patients who exhibit aggressive behaviors and patients who are in need of behaviorally-oriented programming. The development of such a plan -- and its consistent implementation -- is central to the provision of professionally-based psychiatric care. Such a planning process requires sufficient staff to collect data, observe the outcome of interventions, coordinate the results, and, if necessary, reformulate the plan. MMHI does not have sufficient staff available to perform these necessary treatment functions. We find examples of patients who have certain problems identified in an initial screening, but whose treatment plan fails to address them.

Consequently, MMHI patients are subjected to the possibility of increased hospital stays due to lack of progress, increased exposure to risk of harm from the patients' own illnesses or from other patients' illnesses, and the continued exposure to the side-effects of medications.

Progress notes are also not properly maintained. If a patient has more than one psychiatric problem, notes are written in such a manner that it is often not clear which problem a given note might be addressing. Other notes are often so vague as to be worthless.

3. Misuse and excessive use of physical restraints, including restraining patients in locked-door seclusion rooms.

Patients at MMHI are subjected to both an undue amount of bodily restraint and dangerous restraint practices. It is the consensus of our consultants that the lack of adequate staffing and the failure to develop and consistently implement treatment plans have led MMHI staff to resort to inappropriate and excessive restraint practices in order to control patients.

The routine practice at MMHI is to put patients into five-point restraints (a practice where a patient is restrained on a bed and bound by the ankles, by the wrists with the arms to the side, and by a strap across the waist) and to place them into a locked seclusion room. Monitoring is done via closed circuit television and the monitors are located in a separate hallway outside the nurses' station.

This practice is inappropriate and dangerous. Indeed, such a practice can seldom, if ever, be justified. When asked why a patient in a five-point restraint is also locked in a room, MMHI staff consistently reply that it is to protect the restrained patient from possible injury from other patients. The protection of a patient from other patients is not an acceptable rationale for placing a restrained patient into a locked room. A patient so restrained and secluded is at great risk of harm. There are myriad health and safety related problems that restrained patients can experience -- including choking and asphyxiation -- and the risk of harm is only increased when, as here, the patients are locked up and not under direct observation of staff.

Further, staff members are placing patients inappropriately in physical restraints simply because they are confused or disoriented. For example, patients are placed in restraints for "confusion," "getting out of bed," "tumbling, ataxia [muscular incoordination], and being unable to care for self needs," and "disrobing, stumbling and not following directions." These are not professionally justifiable reasons for subjecting patients to restraints.

We also note numerous instances where patients are kept in restraints for longer than what appears warranted by professional judgment. For example, patients are placed into five-point restraints, then released from a portion of those restraints to eat a meal or for some other purpose, then placed back into the five-point restraint. In general, if a patient is calm enough to eat a meal, putting the patient back into full, five-point restraint after eating without restraints -- an indication that the patient is calm --is unnecessary and excessive. We also find

incidents where a patient is reported as "very sedated" and "confused," during times when he is in restraint. Restraining a sedated patient is a substantial departure from accepted standards of psychiatric care.

Physicians' notes often do not justify why a given restraint is necessary. MMHI has no separate policy concerning the use of restraints on patients with medical illnesses. Finally, it does not appear from the documentation that staff are consistently offering patients fluids or toileting while patients are in restraints.

Our consultants conclude that the excessive reliance on restraints is due to a lack of sufficient numbers of adequately trained staff. Too few psychiatrists and other professional and direct care staff translates into a failure to provide and implement individualized treatment plans, which, in turn, results in over-reliance on restraints to control behavior. The lack of appropriate training of staff results in patients remaining in restraints longer than professionally justifiable or being restrained unnecessarily. As well, the failure to properly monitor patients in restraints is due to insufficient numbers of direct care staff to provide such monitoring.

In sum, based on the above stated findings, MMHI residents are subjected to egregious and flagrant conditions that deprive them of their constitutional rights pursuant to a pattern and practice of resistance to the full enjoyment of those rights.