STATE OF OREGON
Department of Human Resources

INVESTIGATION REPORT

DATE OF REPORT: April 27, 2010

INVESTIGATION TYPE: Performance/Policy Violations

FILE NUMBER:

AGENCY: DHS/AMH/OSH

CASE INVESTIGATOR: Billy Martin/Cheryl Miller/Kathy Deacon

Witnesses or Parties Mentioned:

Joe Thurman

Michelle Giblin

INTRODUCTION:

The Office of Investigation and Training substantiated the Oregon State Hospital for neglect for failing to provide the patient with adequate care and treatment.

Additionally, the allegation of staff neglecting the care of the patient on the day of his death was determined to be inconclusive.

BACKGROUND:

A patient on unit 50F was found to be deceased at approximately 7:30 p.m. Time of death was not determined. Patient was last observed up for breakfast and received a PRN medication at 0800 hrs.

SCOPE OF INVESTIGATION:
Did Mr. Thurman violate policy, procedures and hospital expectations in the performance of his assigned duties in completing documentation regarding the patient.

DETAILS

A. "Joseph (Joe)" Interview:
Joe Thurman was interviewed Wednesday, April 28, 2010 in the MD conference room at Oregon State Hospital. Present for the interview was Joe Thurman, Randy Ridderbusch, AFSCME Representative; Kathy Deacon, Chief Nursing Officer; Cheryl Miller, Sr. HR Manager

Mr. Thurman is a 14+ yr employee who has been assigned to ward 50F since January 2, 2005. He has been a RN since July 23, 1997. During the interview with Mr. Thurman, he states he is very much aware of the nursing services policy dated October 16, 2007 that state, "Patients at Oregon State Hospital will receive an RN Summary weekly for 60-days and then monthly."

Mr. Thurman stated that he was on and off the ward for a good part of the year due to a non-work related injury. He was on modified duty with minimal patient contact. He signed an agreement on August 31, 2009 that his modified duties included "Answer phones, work on nursing notes or any nursing related paperwork such as taking off orders or doing med reviews. Doing chart audits." Mr. Thurman stated that after the patient died, he reviewed the chart and was embarrassed to find that there was nothing from August 5. Records provided to Mr. Thurman to review reflect there were no actual RN summaries from June 1 to October 17, 2009 when the patient died.

CONCLUSIONS:
Mr. Thurman has been provided training on policy and procedures and by his own admission is well aware of his responsibility to document on patients assigned to him. Records reflect there are no nursing summaries from June 1, 2009 to October 17, 2009 when the patient died. There were times during that period when Mr. Thurman was both on and off of the ward based on his modified duties. His injury

did not preclude him from completing paperwork and his documentation should have been completed in accordance with the policy and procedure. Mr. Thurman states that he did interact with the patient but on review after the patient's death, stated he felt embarrassment for the lack of charting. According to policy, Mr. Thurman is required to document monthly nursing notes that address the care, treatment and reaction of patients. The lack of documentation during the period June 1 to October 17, 2009 clearly reflect that Mr. Thurman is in violation of the policy for documentation.

Exhibit Index

Ex. #	Description of Exhibit
Ex. 1	Nursing Monthly/Weekly Summary Documentation Policy
Ex. 2	Patient chart notes
Ex. 3	
Ex. 4	
Ex. 5	
Ex. 6	
Ex. 7	
Ex. 8	
Ex. 9	
Ex. 10	
Ex. 11	