STATE OF OREGON
Department of Human Resources

INVESTIGATION REPORT

DATE OF REPORT:	April 29, 2010
INVESTIGATION TYPE:	Performance / Policy Violations
FILE NUMBER:	
AGENCY:	DHS / AMH / OSH
CASE INVESTIGATOR:	Billy Martin, Cheryl Miller, Kathy Deacon

Witnesses or Parties Mentioned:

Michelle Giblin

Mesme Tomason

Sue Johnson

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 Michelle Giblin perform her duties as the supervising RN for Ward 50F, satisfactorily in providing over sight to the ward 50F staff?

DETAILS

A. Michelle Giblin Interview:

Michelle Giblin was interviewed by Cheryl Miller, Sr. Human Resources Manager, Kathy Deacon, Chief Nursing Officer, and Billy Martin, Human Resource Analyst on April 20, 2010 in the Human Resources office at approximately 11:45am.

Michelle is employed as the Mental Health Supervising Registered Nurse (MHSRN) on Ward 50F since April 2009. Prior to this position, she was a RN on 50F. In her present role, Michelle is responsible for supervising approximately 22 staff on the unit and she periodically will cover as the Supervising RN for Ward 50E. Her duties include overseeing the day to day activities of the ward including staff attendance, policy and procedure enforcement, completing performance appraisals for staff, writing job descriptions, training the ward staff, and attending patient IDT meetings.

Michelle has participated in a variety of trainings including, New Employee Orientation, mandatory EDD day, diversity, suicide prevention and assessment, nurse manager training, new manager DHS orientation, HR Essentials, and policies and procedures related to DHS and OSH.

To ensure that staff are complying with the Medication Administration Policy, Michelle would complete audits from time to time as an RN and now as the Supervising RN. When discrepancies were found Michelle would have verbal discussions and send out email to the staff to address the issues. In October 2009 random audits of the MARS were completed and Michelle was working to set up routines to address the issues as there were no real routines then.

As the new Supervising RN, Michelle wanted to focus on addressing issues with staff behavior and bad habits. When she identifies concerns, she talks with the employee that made the mistake and follow up with staff that had recurrent issues.

Michelle reviewed the MARS and PRN's for the Patient and noted several discrepancies. Michelle explained these were the typical problems she would find on her audits and when these discrepancies were identified she would follow up with the responsible staff and verbally reminders the staff of the discrepancies.

Michelle explained that the Nursing Monthly/Weekly Summary Documentation policy states that RN's are to write monthly summaries in patient's progress records. RN's are generally assigned 10 to 12 patients and they are to include in their documentation issues with the patients, medication issues, and other significant events. She makes the staff assignments to patients for monthly summaries. She explained that she was down nurses with one on modified duty who was on and off the ward. RN Joe Thurman was responsible for completing the monthly summaries for the patient and it was her expectation that he complete the monthly nursing summaries. While Joe Thurman was off the ward on modified duty, she considered reassigning his charting duties to other RN staff but as he was on and off the ward, she expected him to be current on his charting. All the staff on Ward 50F struggled to stay current on the charting. There were no priorities set for documentation. Michelle would talk about documentation at the inter-shift meetings and through email as well as verbally to staff.

Monthly summaries have always been the standard. Michelle recalled doing a chart audit sometime around July 2009 and the results varied. Some staff charted better than others and that she noticed charting issues even back when she was a unit RN on the ward. It was a chronic problem. No staff came to Michelle to ask for help to get the charting caught up or to ask for overtime to get caught up. Michelle did not offer to assist staff with charting and did not take the issue up the chain of command. Michelle wasn't sure if documentation issues were discussed in the weekly MHSRN meetings.

Michelle stated Case Monitors are required to document weekly. All staff are aware of that requirement through daily reminders. Acuity was high on the unit and staff did not always have time to complete charting. It was a

struggle and she is not sure if it was possible for staff to get them done as required. After reviewing the progress notes from Patient 59245's chart, Michele stated they were not acceptable. Michelle stated that three month gaps without documentation is excessive but there may be similar patterns with other patients.

Michelle stated that the patient received much more staff attention than is reflected in the charting. When the unit is short staffed, the priority has been to ensure that changes in the patient's condition or behavioral problems were documented rather than the routine information.

B. <u>Mesme Tomason Interview</u>:

Mesme Tomason was interviewed by Cheryl Miller, Sr. Human Resources Manager, Kathy Deacon, Chief Nursing Officer, and Billy Martin, Human Resource Analyst on April 20, 2010 at 9:00am in the Oregon State Hospital Superintendents Office.

Mesme has been employed as the Assistant Nursing Director of Forensics for approximately 4 years and her responsibilities include supervision of the Mental Health Supervising Registered Nurses, providing information to nursing supervisors such as policy changes and importance of patient care, attend meetings, participating in committees as needed, completing staff performance appraisals, meeting with clinical supervisor on a quarterly basis, involve Human Resources and clinical management as needed, complete employee requisitions, handle staff and union issues, respond to grievances, and she is on call 24 hours a day. Mesme shares the load of direct supervision for approximately 20 nurse supervisors with Nurse Manager Sue Johnson. Sue Johnson reports to Mesme and was responsible for the supervision of the nursing supervisors in the 50 building, with the exception of 50G, of which Mesme supervised along with other problematic areas.

She makes the supervising nurses aware of her expectations for them through weekly meetings, email communications, periodic rounds, monthly HR meetings, and frequent verbal conversations. She follows up with some supervising nurses more than others when additional help is needed. Most direction is generally provided verbally to the supervising nurses and the supervising nurses have the expectation to follow up with her when those expectations are not met. Weekly meetings are conducted with nursing

supervisors and in that meeting she discusses and gives direction to her staff. At times the expectations are put out in writing such as the recent cell phone policy and those require follow up as part of the communication.

Supervising nurses receive training and orientation in their roles through the use of checklists and other tools but they do not attend any form of traditional training. Mesme expects the supervising nurse will attend the HR Essentials training and the DHS mandatory trainings. She expects they sign up for and complete the training and she will review the employee's job description with them. At times, new employees may be assigned to shadow another supervising nurse as needed. Mesme will also check in on the employee frequently to see how they are doing. Part of the training is to check off the policies on the orientation checklist and asking if they have questions. This policy training is more for new supervising nurses from outside of the OSH system who should already be familiar with the policies and procedures. Supervising nurses are expected to train their staff on OSH policies.

In October 2009, Ward RN's were expected to write monthly summary notes in patient's progress records. Case Monitors were expected to make weekly notes in the progress records. Mesme explained it is the supervising nurse's reasonability to ensure the RN's and CM's on the ward are meeting these expectations.

Mesme explained the nurses should have noticed the missing notes from the progress record and the supervising nurse should have known as well. The supervisor should have assigned the patient workload to other nurses or she should have covered it herself. If there were any concerns on documentation the supervising nurse should have brought it forward to Mesme but she did not. If there are issues of documentation not being completed, it is the Supervising Nurses responsibility to address the issues with the employee and to help when needed or to ask for help if needed.

Mesme explained that she didn't believe that Michelle would know to ask for help if documentation was not being completed as the unit had several issues with clinical team turnover, and a dysfunctional IDT.

C. **Sue Johnson Interview:**

Sue Johnson was interviewed by Cheryl Miller, Sr. Human Resources Manager, Kathy Deacon, Chief Nursing Officer, and Billy Martin, Human Resource Analyst on April 20, 2010 at 10:35am in the Superintendent's Office of the Oregon State Hospital.

Sue is a Nurse Manager in the forensics program and has held that position for approximately 4 years. Her duties and responsibilities include crisis management, stepping in as the supervising RN when needed, attending meetings and trainings. She directly supervises 8 MHSRN's and assists them in their jobs. She assists the supervising nurses with employee problems, mentors the supervising nurses, helps them find answers to problems, and if they are not doing their jobs she involves HR. She is involved in the discipline process with other staff as needed. She works together as a team with Mesme Tomason to cover all of the forensic staff and she was responsible for covering the 50 building. Sue shares her expectations with her staff through weekly meetings, clinical supervision, and by visiting the units and reviewing problems on the units.

To ensure her expectations were being met, she would know by whether or not they were doing their jobs and the work was being completed or not. She would hear from her staff during the weekly supervising nurse meetings, during the monthly HR meetings, and through email.

As most supervising RN's have already worked on the floor, some of the job is already known based on previous work experience. Sue makes sure they sign up for EDD classes and HR Essentials training. Sue has a book that she reviews with new staff including policies, 801's, RN summaries and anything that is important is in the book including DHS, DAS, OSH, and nursing policies they need to be aware of. With regards to training on OSH policy, the supervising nurses get what's learned through EDD and the weekly meetings. After NEO, she will meet with the supervising nurse and have them shadow other supervising nurses as needed depending on the need and their skills.

Sue ensures her supervising nursing staff are training their staff on OSH policy by follow up and direction through email, meetings, phone conversations, attending overlap meetings on the wards, doing competencies and training.

RN's were expected to complete monthly nursing summaries and Case Monitors were expected to complete weekly summaries. RN's and CM's are trained as part of their orientation and the Supervising Nurse is to follow up to ensure the charting is being completed as required. When nursing staff are away from the workplace for extended periods of time, the supervising nurse is responsible for assign and delegating the work of the absent nurse.

To address the non-compliance issues identified in the MARS and PRN's Sue is always looking at it, talking about it with supervising nurses, auditing, and Joint Commission looks at it as well. The supervisor should address the issues with the med giver.

In reviewing the patient's progress record, Sue stated it is unacceptable and summaries should be done monthly and that if a staff is out, their workload should have been reassigned. Case monitors should be documenting weekly and the Supervising Nurse should be assigning staff to patients. The supervising nurse is responsible for ensuring the RN summaries and case monitor notes are completed as required. The supervising nurse should be aware of the expectation as it is discussed with the supervising nurse and discussed in the weekly meetings. The supervising nurse should be following the process if staff are not complying with the expectation. They should be taking with staff, warning staff, training them, etc, then going to discipline if needed. Sue believes the Supervising Nurses understand the expectations by the policy and procedure and Mesme's directives and expectations.

CONCLUSIONS:

The evidence and interviews support the following conclusion:

Michelle Giblin failed to perform her duties as the Supervising RN for Ward 50F in that she failed to provide adequate over sight to the ward 50F staff. Michelle, as a new supervisor should have been able to looked to her supervisors for guidance and leadership in helping her develop in her role as a supervising nurse. Michelle Giblin promoted on the same ward that she worked as a MHRN. When she promoted, she performed her new duties in the same manner as the previous supervisor because her leadership team failed to provide her with the resources she needed to be successful.

Exhibit Index

Ex. #	Description of Exhibit
Ex. 1	Progress Record from June 1, 2009 through October 17, 2009.
Ex. 2	MARS and PRN Records for the Patient from August 2000 through October 2009.
Ex. 3	Oregon State Hospital Nursing Services Department Policy – Case Monitor, Role and Responsibility dated September 4, 2007.
Ex. 4	
Ex. 5	
Ex. 6	
Ex. 7	
Ex. 8	
Ex. 9	
Ex. 10	
Ex. 11	