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:

Sue Johnson

Michelle Giblin

Mesme Tomason

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 Sue Johnson perform her duties appropriately in providing supervision and oversight to subordinate staff on ward 50F?

DETAILS

A. 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. Due to the addition of the treatment malls, she has not been able to visit the units as she did in 2009. Mesme did not attend these unit visits with her with the exception of 35C.

To ensure her expectations were being met, she would know by whether or not they were doing their jobs and when the work was not being done, she would hear about it. 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. She makes sure they sign up for EDD classes and HR Essentials training. She 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 train 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 assigning and delegating the work of the absent nurse. It is not the nurse's responsibility to have their work covered by other staff. Since October 2009, there has been ongoing training for staff on writing in the patient's progress notes. RN's can either hand write or use the new electronic summary report.

In reviewing the PRN and MARS for the patient, Sue identified several issues. To address the non-compliance is an ongoing effort, she 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. 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, discussed in the weekly meetings. The

supervising nurse should be following the process of 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.

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.

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Weekly meetings are conducted with nursing supervisors, including Sue Johnson, and in that meeting she discusses and gives direction to her staff. The direction is verbal and the expectation is that the staff will follow that direction however she does not generally follow up to ensure it is therefore Mesme agreed she does not always know if her staff are following her

direction or if they are meeting her expectations. 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 are expected to train their staff on OSH policies and if they are not training their staff, it is Mesme's expectation that someone will let her know as she has too many people and too many things to do to ensure the supervising nurses are doing their jobs. Mesme relies on Sue Johnson for assistance in this responsibility.

Kathy Deacon, Chief Nursing Officer, reviewed her findings of a recent file audit that she completed where the RN and CM notes have not been completed in the last four months which is not in compliance with the direction that Mesme has been giving her staff. Mesme explained that she is addressing those types of problems and following up with staff weekly and will take those issues forward to HR when they are identified.

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. Mesme explained she took this information to Sue Zakes and John Lockey however she did not take it forward to the Chief Medical Officer.

C. <u>Michelle Giblin Interview</u>:

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.

The chain of command for Forensic Nursing Services starts with the RN on the unit reporting to the MHSRN. The MHSRN reports to Sue Johnson, the Nurse Manager and the Nurse Manager reports directly to Mesme Tomason, the Assistant Nursing Director of Forensics. Michelle reports that the unspoken expectations on the ward are that she is expected to do her job and show up for work. Sue Johnson periodically will come to the ward to visit.

Michelle explained you felt nursing documentation being late or non-existent was a systemic problem in that you heard this from conversation with other people, other supervisors and other staff saying it was a problem on their units. Michelle didn't take the issue up the chain of command as she thought the problem was everywhere. They have weekly MHSRN meetings and was sure it came up in the meetings but could not recall specifically and could not recall if she brought it up in the meetings. She did recall having discussions with other MHSRN's outside of these meetings.

CONCLUSIONS:

The evidence and interviews support the following conclusions:

A. Sue Johnson failed to provide adequate supervision and adequate oversight of MHSRN Michelle Giblin in that Michelle Giblin did not receive adequate training to perform the duties of a Supervising Nurse.

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	