

Investigative Report of the Premature Death of (Patient Name Redacted)

On September 1, 2004, (Patient Name Redacted), age 46, choked to death on a double portion of hot dogs while in the quiet room at the Arkansas State Hospital (“ASH”).

On September 29, 2004, Disability Rights Center (“DRC”) staff began an investigation of (Patient Name Redacted)’s death. Initial reports of (Patient Name Redacted)’s death suggested that he died in a seclusion/restraint room.

A. Background Information

(Patient Name Redacted) was a patient at ASH on Unit 3 Upper from July 17, 2003, until his death on September 1, 2004. He was part of the ‘General Adult Program’ residing on a unit comprised of 30 beds for both males and females. Per the ASH Plan for Patient Services 2003, “the General Adult Program emphasizes an acute approach that seeks to return patients to community settings as soon as their symptoms are in substantial remission. The current average length of stay on these units is approximately 20 days.”¹

DRC advocates Trevor Arnett and Dee Blakley began the DRC investigation by interviewing the ASH Administrator regarding reports DRC received that a death had occurred in a seclusion/restraint room on 3 Upper. (Name Redacted) initially denied that a death had occurred in a seclusion room. Further investigation revealed that a death had occurred on September 1, 2004; however, ASH staff referred to the room where (Patient Name Redacted) died as a “quiet room.”²

DRC obtained DHS Incident Report #13858 written by (Name Redacted), which indicated that (Patient Name Redacted) died of an “obstructed airway” on Unit 3 Upper in the quiet room. The incident report indicated that his death occurred on September 1, 2004, at 7:50am.³ The incident was described further in the report as follows:

¹ According to data obtained from the ASH Quality Improvement Department during the writing of the first DRC investigation report, the average length of acute stay for adults is 61.25 days.

² The ASH Policy and Procedure Manual defines the “Time Out/Quiet Room” in policy #11.16.01, Use of Seclusion. The policy states:

Use of Time Out or Quiet Room is considered a behavior management treatment intervention that should be therapeutic and foster adaptive behaviors. The following procedure should be followed when using Time Out or Quiet Room.

Limit to no more than 30 minutes.

Occur in an unlocked room.

Educate the patient about the conditions under which TO or QR are used.

Prohibit the use of intimidation, force or threat. (Emphasis added.)

³ The time contained in Incident Report Form #13858 was inaccurate. The incident actually occurred in the evening around 7:50pm.

The patient was found lying in the quiet room unresponsive. A “DR STAT” and 911 were called and CPR was started. The Heimlich maneuver was performed to remove the airway obstruction. A physician arrived and assisted with CPR. When MEMs arrived they attempted to intubate the patient without success due to airway obstruction. The patient was transferred to UAMS emergency room and pronounced dead.

Additionally, it was noted on Incident Report Form #13858 that a “root cause analysis will be performed on the incident.”

DRC obtained ASH medical records for (Patient Name Redacted) leading up to the time of his death. ASH’s medical records indicated (Patient Name Redacted)’s most recent admission took place on July 17, 2003, as a referral from Mid South Health systems. “(Patient Name Redacted) presented to the ASH with complaints of worsening auditory hallucinations for four months” according to the Discharge Summary dictated by (Name Redacted), on October 14, 2004. Furthermore, (Patient Name Redacted) was noted at the time of admission to be “very impulsive and difficult to manage and control...” His diagnosis at the time of his death as noted by (Name Redacted), Section Chief and Attending Physician in the Discharge Summary was: AXIS I Schizophrenia, Chronic Paranoid Type, AXIS II Mild Mental Retardation.⁴

Throughout the course of treatment, (Patient Name Redacted)’s treatment team attempted various approaches to improve his physical and psychological condition. He was sent to the University of Arkansas for Medical Sciences (“UAMS”) Medical Center from August 8, 2003, through August 15, 2003, for what was reported as “neuroleptic malignant syndrome.” He was treated and subsequently returned to ASH after being “stabilized.” In February 2004, (Patient Name Redacted) underwent Electro Convulsive Therapy (“ECT”) after ASH obtained a special court order⁵ to conduct ECT. The ECT was discontinued on July 9, 2004, because it “seemed to be having less effect on the patient’s condition... the treatment team felt that further ECT was not indicated since it was not showing any noticeable response on the patient’s condition.”⁶

Notation in his medical records stated that (Patient Name Redacted) was being intrusive to other patients on the unit and an elopement risk. Further indications existed within the medical record that he was frequently agitated and required occasional restraint and seclusion. During the month prior to his death, August 2004, (Patient Name

⁴ Arkansas Department of Human Services Division of Mental Health Services, Discharge Summary, Date of Dictation 10/14/2004, Re: (Patient Name Redacted) MR #600877, By: (Name Redacted), M.D.

⁵ See ACA § 20-47-218(b)(3)(B).

⁶ Arkansas Department of Human Services Division of Mental Health Services, Discharge Summary, Date of Dictation 10/14/2004, Re: (Patient Name Redacted) MR #600877, By: (Name Redacted), M.D.

Redacted) was placed in “seclusion” three times,⁷ as it is defined by ASH Policy 11.16.01, *Use of Seclusion*, in addition to being placed in the Quiet Room numerous times.⁸ The use of the ‘Quiet Room’ for (Patient Name Redacted) was described as, “a normal, routine thing...”⁹

(Patient Name Redacted)’s last moments were spent in one of two quiet rooms located on Unit 3 Upper. Quiet rooms are approximately 10’x10’ and are located on each unit. They usually consist of a bare room with a window covered in plexiglass, but occasionally contain a mattress. Cameras are located in the back right corner of the room and transfer images of the room and its contents to the nurses’ station. The nurses’ station serves as a barrier to an additional room connected by a doorway; this room contains a table and chairs and is primarily used for unit staff meetings and breaks. Going to the back of the meeting and break room reveals two doors, one on the right and one on the left, which open up into quiet rooms. The quiet rooms can also be accessed through adjacent door that lead to a short hallway and eventually the patients’ day area.

On September 1, 2004, (Patient Name Redacted) was pronounced dead at 7:40pm in the UAMS Emergency Room after attempts at resuscitation failed. Previous to (Patient Name Redacted)’s transfer to the UAMS Emergency Room, he had been found unconscious and unresponsive in one of the ASH quiet rooms. A progress note entered in (Patient Name Redacted)’s medical record by an RN shortly after his death recounted the events of that evening as follows:

9/1/2004 1950 Nsg Obs Patient was served dinner around 6:00pm, about 30 minutes later I asked the MHW to check on pt. The MHW replied “he’s okay”, about 15 minutes later I observed the patient on the monitor and appeared to be lying awkwardly- so the MHW and myself went to check on him and it was at this time pt was observed not breathing, and unresponsive. The MHW left to called Dr. Stat and 911 I immediately begin CPR, upon the return of the MHW we performed the Heimlich maneuver at this time We were able to remove undigested food from his mouth- we started CPR again, then (Name Redacted) arrived he begin to assist with CPR at approximately 1853. Pt. was not moving air and multiple sweeps were done removing undigested food. MEMS arrived at 1858 and took over CPR and other interventions. Pt. was transferred to UAMS at

⁷ Progress Notes located in (Patient Name Redacted)’s most recent Medical Record documented 3 occasions he was placed in seclusion/restraint during the month of August 2004: 8/10/2004, 8/13/2004, 8/17/2004.

⁸ Progress Notes located in the medical records from the month of August 2004 documented that he was in the quiet room in excess of forty-nine times. One such Progress Note dated August 25, 2004, at 1:40pm stated that (Patient Name Redacted) “remains in Quiet Room most of the shift.”

⁹ This quote was taken from the transcription of a taped interview with (Name Redacted), (Patient Name Redacted)’s attending nurse at the time of his death. The interview was conducted on October 6, 2004, by DRC staff Trevor Arnett and Susan Pierce.

approximately 1926- pt. was pronounced deceased at 1942 according to the staff at UAMS.

The cause of (Patient Name Redacted)'s death, according to the Arkansas State Crime Lab, was determined to be "Asphyxia D/T Choking on Bolus of Food (Hotdog)."¹⁰

B. Summary of the Chronology of Events Prior to (Patient Name Redacted)'s Death

The following chronology begins on the evening of September 1, 2004, and focuses on the times and events leading up to (Patient Name Redacted)'s death. This chronology was established by using evidence and statements collected from several sources. Please note that this chronology does not necessarily follow the exact time and chronology presented in the 'Root Cause Analysis' written by ASH.¹¹

- (Patient Name Redacted)'s death occurred during the evening shift from 3pm-11pm. According to the recorded statements of MHW (Name Redacted) and RN (Name Redacted), (Patient Name Redacted) was in the quiet room at the beginning of the 3-11pm shift.
- According to the 'Root Cause Analysis' prepared by (Name Redacted), RN, the actual staffing for Unit 3 Upper the evening of September 1, 2004, 3pm-11pm shift consisted of one RN, one Licensed Psychiatric Technical Nurse, one Licensed Practical Nurse, and three Mental Health Workers.
- The 3pm-11pm shift on September 1, 2004, was described by MHW as being a "normal day."¹² This was further corroborated by RN when she described the same evening shift as "a normal day... the patients were just going through their regular routine."

September 1, 2004

<i>Time</i>	<i>Event</i>
6:00pm-6:30 pm	(Patient Name Redacted) was served his dinner in the quiet room.

¹⁰ The cause of death is indicated in the information received from the 'Report of the Coroner's Investigation, Case: 04-2005' to which is attached the preliminary finding of the Arkansas State Crime Laboratory, Case Number: 729-04, Cause Of Death.

¹¹ ASH submitted its Root Cause Analysis, Sentinel Event Report to JCAHO in October 2003, as required by JCAHO in order to maintain its accreditation. A sentinel event is defined by JCAHO as an unexpected occurrence involving death or serious psychological injury, or risk thereof. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

¹² MHW Recorded Interview, 10/6/04

Root Cause Analysis indicated he was served dinner at 6:30 pm; however, RN states on a medical record progress note dated 9/1/2004 at 7:42pm that (Patient Name Redacted) was served dinner around 6:00 pm.

LPN staff member on 3 Upper September 1, 2004, wrote in a statement for ASH investigators dated September 2, 2004, that (Patient Name Redacted) was served dinner at 6:30 stating that “(Patient Name Redacted) didn’t get his tray from MHW until approx. 1830 while he was in the quiet room. He received his tray at this hour because he was being cleaned up prior to receiving his dinner.”

(Patient Name Redacted)’s Nutrition Follow Up dated 8/31/2004 indicated that he was ordered double portions of meals to help increase his weight. On the evening of his death his dinner’s main course consisted of hot dogs.

6:30pm-6:45pm

MHW checked on (Patient Name Redacted) at the request of RN. RN also stated that MHW had indicated that (Patient Name Redacted) was “okay.” The Root Cause Analysis reported that, “at approximately 6:30 the patient was checked on by the Mental Health Worker and found to be ‘ok.’”

RN stated in the taped interview with DRC staff that from the time (Patient Name Redacted) was served his dinner and the time he was checked on was “about thirty minutes.” Furthermore, RN stated that MHW had “just thought he had eaten and laid down and went to sleep.”¹³

MHW indicated in his taped interview with DRC staff on 10/6/2004 that he was asked to check on (Patient Name Redacted) an hour after he delivered the food. He stated, “And I went and I looked... I looked at him and at first I thought he... the way he was laying it just looked like he was asleep until, you know... and I was like oh he... he, you know, he looks okay. He look just like he is sleeping.” He further stated that “... I didn’t pay any more mind to it. I didn’t ‘cause I didn’t want to wake him up.”¹⁴

¹³ RN, Recorded Interview, 10/6/2004

¹⁴ MHW, Recorded Interview, 10/6/2004

6:45pm

(Patient Name Redacted) “was found unresponsive by the R.N. in charge of the unit.”¹⁵ RN stated in the progress note written shortly after (Patient Name Redacted)’s death that, “about 15 minutes later I observed the patient on the monitor and appeared to be lying awkwardly- so the MHW and myself went to check on him and it was at this time pt was observed not breathing, and unresponsive.”¹⁶ Upon finding (Patient Name Redacted) unconscious, RN indicated in her progress note following the incident that she began CPR and sent the Mental Health Worker to call 911 and a ‘Dr. Stat.’ RN stated that when she found (Patient Name Redacted), she discovered “he had a pulse but he was not breathing.”¹⁷ The ASH medical record and interview both corroborate that CPR and the Heimlich maneuver were initiated.

MHW claimed that when he discovered (Patient Name Redacted), he and RN “started clearing his mouth out and tried doing CPR and chest compressions on him...He wasn’t breathing. So, you know, both us real nervous. She was trying to work on it... I grabbed him and I picked him up... I was trying to do the Heimlich maneuver on him to get the food out and all I was getting out was just wheezing. You know, I was pushing the air in that was already. He wasn’t moving or responding or anything, you know.”¹⁸

6:51pm

Metropolitan Emergency Medical Services (MEMS) indicated in their records that they received an emergency call at 6:51. The caller to emergency services identified himself as (Name Redacted).¹⁹

6:51pm-6:56pm

Doctor arrived on Unit 3 Upper and was taken to (Patient Name Redacted), still in the quiet room. Doctor stated that upon his arrival to the unit, he was taken to the quiet room. He took over chest compressions while the nurse continued rescue breathing. Doctor noted that, “...the patient’s chest

¹⁵ Root Cause Analysis, p.1

¹⁶ Progress Note, Medical Record #600877, 9/1/2004, 7:50pm

¹⁷ RN Recorded Interview, 10/6/2004

¹⁸ MHW, Recorded Interview, 10/6/2004

¹⁹ MEMS emergency call log and tape of 911 call

was not rising and falling as expected. I then attempted finger sweep of the mouth and removed several pieces of undigested food (hot dog).” He further indicated that, “after 1-2 minutes PSO arrived with the AED and chest leads were placed. The AED stated: ‘Shock not indicated, check airway.’ I then rolled patient onto side and attempted Heimlich Maneuver followed by additional finger sweeps of the oral cavity – again rescue breathing were performed. With the aid of staff we placed patient in upright position and I again performed multiple Heimlich Maneuvers and manual sweeps of the oral cavity. Again food was removed but airway did not fully clear.”²⁰

- 6:56pm MEMS arrived on the scene at 6:56pm.²¹ The MEMS Patient Care Report indicated that when the MEMS crew arrived, they found a 46-year-old white male lying on the floor. The report indicated that (Patient Name Redacted) did not have a pulse. MEMS was unable to intubate (Patient Name Redacted) after several attempts.
- 7:10pm The EKG report obtained from the MEMS record indicated that (Patient Name Redacted)'s heart rate was minimal to non-existent.
- 7:27pm (Patient Name Redacted) arrived at UAMS Medical Center Emergency Room. MEMS records indicated (Patient Name Redacted) arrived at 7:27pm. A “code blue” was called by UAMS ER staff.²²
- 7:35pm UAMS Medical records indicated that (Patient Name Redacted) was triaged at this time; however, according to medical records documentation, medical intervention was initiated immediately upon his arrival.²³
- 7:40pm (Patient Name Redacted) was pronounced dead by the attending ER physician. (Patient Name Redacted)'s death was initially identified as a “cardiac arrest.”²⁴

²⁰ Doctor written statement dated 9/3/2004, titled ‘Sentinel Event 9/1/2004’

²¹ MEMS Emergency Call Log, Patient Care Report

²² UAMS-ER medical record 121525074245

²³ UAMS-ER medical record 121525074245, which includes a list of the specific medical interventions. Interventions utilized include intubation, IV, and resuscitation efforts.

²⁴ UAMS-ER medical record 121525074245

- 8:00pm 'Emergency Department Nursing Assessment' indicated that the Coroner's office was notified.
- 9:15pm (Patient Name Redacted)'s body was discharged to the Coroner and his remains were transported to the Crime Lab for autopsy and further investigation.²⁵

C. DRC's Areas of Concern and Findings

Throughout the course of the DRC investigation of (Patient Name Redacted)'s death, DRC encountered areas of concern, which had a direct impact on patient safety and contributed to (Patient Name Redacted)'s death. Identified below is a list of the areas of concern and findings of DRC's investigation.

1) FAILURE TO MEET THE STANDARD OF CARE FOR ACUTE PSYCHIATRIC PATIENTS

a. Routine checks on patients to verify safety were not performed in the case of (Patient Name Redacted).

Maintaining a safe environment by routinely accounting for an acute psychiatric patient's whereabouts and status is critical to ensuring his/her safety. Admission to an acute psychiatric unit results from many factors. However, one consistent factor and standard is that one "poses a clear and present danger to himself or herself or others."²⁶ The very nature of an acute psychiatric population necessitates regular check-ups as it is inherently a vulnerable group with a higher than normal probability for self-harm or careless disregard for personal safety. Therefore, DRC disagrees with the assessment noted on page 6 of the ASH Root Cause Analysis that follows:

- Q. What can be done to protect against the effects of uncontrollable factors?
A. Other than the difficulty in finding a facility that would accept the patient so we could discharge him, **it was determined there were no other uncontrollable factors involved in the incident.**

Patient placement was a problem due to the patient's dual diagnosis of Mental Illness and Mental Retardation. At the time of the patient's death, the patient had been in the hospital for over a year. (Emphasis added.)

Failure to adequately supervise a patient, particularly one with known cognitive limitations and a high level of acuity was a controllable factor. It is a reasonable consideration for patients to have brief moments where they are not under direct watch

²⁵ Coroner's Investigation, Case: 04-2005

²⁶ See ACA § 20-47-207(c).

from staff; however, ASH does not have a clear policy or standard that adequately addresses the accounting of patients of a unit. Had ASH fully developed and established guidelines to check on patients, it is less likely that (Patient Name Redacted) would have been left unsupervised in excess of 30 minutes and then regarded as 'sleeping' when he was actually in distress.

(Name Redacted) provided insight into the lack of a procedure requiring regular checks on the patients and highlighted the factors that contributed to (Patient Name Redacted)'s death:

DRC staff Susan Pierce: But you're saying he was already in there [Quiet Room] when you came on shift. Right. So, you don't... and did you say you don't know if he was placed in there [Quiet Room] or whether that was one of the times he went in by himself.

A: Ah... I'm not sure but... like I said most of the time that's where he is. You know, and that's where he chooses... where he chose to be.

Susan: When he was in there...ah... like even when he just went in himself did ya'll... was it just kind of you checked on him when you could or did the nurses or the workers did anybody... was it kind of like, well we better check on him every thirty minutes or... I mean, how did ya'll do that.

A: Well, I can just speak for me personally, what I do.

Susan: Okay.

A: 'Cause I'm responsible for like bathing him and, you know, its part of my job shift. I would go in there and check him to see... because a lot of times he wouldn't go to the bathroom. He would just do it where he was. So, you don't want that to setup on him, you know. So, I go in there and check him maybe, I'd say two or three times a night, you know. 'Cause there are other people that's going to be in and checking on him also.

Susan: Right.

A: Ah... but no one was... was particularly assigned to him, you know what I'm saying, it was such a normal thing for him to be back there. It was like, almost like his room... you know.²⁷

DRC's FINDING:

Current ASH policies and practices regarding the routine monitoring of acute patients by staff are inadequate. ASH failed to instruct staff as to the frequency with which patients must be monitored.

²⁷ MHW, Recorded Interview, 10/6/2004

b. The Mental Health Worker inaccurately identified (Patient Name Redacted) to be asleep when he was choking to death.

Physical observation and/or a status check of the patient by staff should require a brief assessment of the patient's well-being, which includes noting the presence of respiration. It is common practice for psychiatric facilities to require documentation or special attention to the rise and fall of a patient's chest when he/she appears to be sleeping, particularly for a patient who is isolated from the therapeutic milieu.²⁸ Failure to uphold this standard of care caused (Patient Name Redacted) to be incorrectly observed by staff as being "asleep," when in fact he was choking to death. This inaccurate observation made fifteen (15) minutes prior to his discovery by the R.N. severely limited the success of any rescue attempt.

ASH's disregard for (Patient Name Redacted)'s safety was reflected by a MHW and an RN during their October 6, 2004, interviews with DRC.

A: I took him his dinner

Susan: In the Quiet Room?

A: In the... in the quiet room 'cause it was... it was where he wants to be that's where he ate. So, I took it in there and gave it to him. He was on the mattress... he was doing his thing of rocking... doing his thing. I set the tray down beside him. I tried to get him to start eating right then but I put it next to him and he just took it and set it on the floor and continued on. So...

Trevor: Continued on rocking?

A: Continued on rocking, you know. And ah... I left outa room, you know. Because, I mean no one was assigned to him or anything, you. And I went and I was doing all the duties that I had to do that evening. And I'd have to say about an hour later I was asked, you know, how was he doing. And I said well I hadn't... 'cause I hadn't been back there no more. And I went and I looked... I looked at him and at first I thought he... the was he was laying it just looked like he was asleep until, you know... and I was like oh he... he, you know, he looks okay. He looks just like he's sleeping...

Several questions later...

Susan: Did he have his back to you when you came to the door or was he facing you?

A: Naw. He was... he was facing me. And I looked at him and... I mean... I mean as long as I have been here I figure, he would go to sleep, you know. So, I

²⁸ See 42 CFR § 482.13

didn't pay any more mind to it. I didn't 'cause I didn't want to wake him up. Ah... and I was coming back into the room and the nurse was going into the quiet room.²⁹

The following statements are taken from the interview with the RN:

Trevor: And what was the time frame, from your estimate or if you know exactly, between when he was served his tray and somebody checked on him.

A: I would say it was about thirty minutes.

Trevor: About thirty minutes?

A: Uh-huh. That was to give him time to eat and then they always collect his food and get him to the bathroom and do all those things that they usually do.

Trevor: Okay. And then after the thirty minutes then you started taking... I'm trying to put this into like a chronological order or time frame that I can understand and follow. So, its thirty minutes and then a mental health worker went and checked on him. Okay.

A: Right. And so... ah... that's the way I understand it when he said that he just thought he had eaten and laid down and went to sleep. And I said that's pretty normal for him to do. So, about ten or fifteen minutes later I got up... because I was sitting out front because of the patients and we had so many patients. And so, after he was gone and coming back to the conference room and I kind of looked at the monitor and saw him looking and then that's when I went in there.

Susan: How was he laying when you looked on the monitor... how was he laying?

A: He was laying on a mattress...ah... you know, kind of in a fetal position ...³⁰

In addition to the above statement, (Name Redacted) indicated in her interview that (Patient Name Redacted), "had a pulse but he was not breathing" at the time she found him unconscious in the quiet room. Therefore, as a result of staff's failure to verify (Patient Name Redacted)'s respiration at the thirty (30) minute interval, he may have suffered for fifteen (15) minutes or longer isolated from others in the quiet room.

²⁹ MHW, Recorded Interview, 10/6/2004

³⁰ RN, Recorded Interview, 10/6/2004

DRC's Finding:

Based on witness testimony and the sequence of events, ASH staff failed to make an accurate assessment of (Patient Name Redacted)'s condition at the 30-minute check. Furthermore, staff relied on assumptions of past behavior as an excuse to disregard the need for further examination, which is inconsistent with the standard of practice for psychiatric hospitals and does not adequately meet the needs of such a population. ASH's failure to provide a consistent means to determine and document the status of patients on the unit contributed to (Patient Name Redacted)'s death.

2) FAILURE TO FOLLOW ESTABLISHED POLICIES AND PROCEDURES³¹

ASH failed to meet its own standard of care outlined in ASH policies and procedures. Specifically, the following policy was violated on numerous occasions in relation to (Patient Name Redacted):

ASH Policy and Procedure Manual defines "Time Out/Quiet Room" in ASH Policy #11.16.01, *Use of Seclusion*. The policy states:

Use of Time Out or Quiet Room is considered a behavior management treatment intervention that should be therapeutic and foster adaptive behaviors. The following procedure should be followed when using Time Out or Quiet Room.

Limit to no more than 30 minutes.

Occur in an unlocked room.

Educate the patient about the conditions under which TO or QR are used.

Prohibit the use of intimidation, force or threat. (Emphasis added.)

According to staff members interviewed and nursing notes, (Patient Name Redacted) had been in the quiet room on Unit 3 Upper since the beginning of the 3pm to 11pm shift with the exception of a brief period when he was 'cleaned up.' The following statement revealed that it was standard practice for (Patient Name Redacted) to remain isolated from the other patients:

Excerpt from the 10/6/2004 interview with the RN:

Trevor: Just from what you know and your experiences how does the quiet room operate and why do people wind up in there and how long do they stay there? Or anything you want to tell me about the quiet room.

A: Well... umm... the quiet room is... it was used differently for (Patient Name Redacted). It was not because we were trying to protect the other patients from

³¹ These findings are consistent with the systemic conclusions of DRC's previous investigation report, entitled Dirty Laundry: Investigation Report of Alleged Patient Abuse at the Arkansas State Hospital, published June 6, 2005.

him, we were trying to protect him from the other patients. And so it was really just the only place that we had that we could put him where he would be, you know... where couldn't anybody get to him really. But we always kept the door open and he would be in and out. And... ah... we would try to, you know, keep up with him because we know that he did get in somebody's face or, you know, doing some hitting. When he's doing things like that he could really get hurt, you know. So, we didn't use the quiet room like a place of restraint or seclusion for him. It was a place of safety for him.

The usage of the quiet room for (Patient Name Redacted) was outlined further by the mental health worker; he stated in his October 6, 2004, interview that, "I would say 80% of the time he was back there [quiet room] because he wanted to be back there." Progress notes located in (Patient Name Redacted)'s medical record for the month of August 2004 verify that he was in the quiet room no fewer than forty-nine (49) times.

Despite proffered justifications for the frequent use of the quiet room as "a place of safety," there was no indication by (Patient Name Redacted)'s treatment team that this was an appropriate therapeutic intervention. Furthermore, there was no indication noted in the medical record that verified (Patient Name Redacted)'s psychiatrist approved this type of treatment or intervention as part of an appropriate therapeutic intervention.

The following is an excerpt from ASH Policy 11.12.01, *Treatment Planning*:

The MTP [Master Treatment Plan] meeting results in the development of the MTP document. That document includes clinical problems, patient strengths, preliminary discharge plans, treatment goals, more specific objectives, and treatments to be utilized in reaching those objectives.

(Patient Name Redacted)'s Master Treatment Plan, developed by his ASH treatment team, did not address the use of the quiet room as an appropriate clinical intervention for him. Semantically interchangeable with ASH's definition of "quiet room," ASH's accrediting body, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), defines "time out" in standard PC.10.110, *Policies and procedures govern the use of time-out*. "The use of time-out is consistent with the client's plan for care, treatment, and services." The plain language reading of the JCAHO standard requires that the use of the "quiet room" as an appropriate intervention must be consistent with a patient's master treatment plan.

Due to the failure of (Patient Name Redacted)'s treatment team to address the use of the quiet room in his treatment plan, he was left in the quiet room (time out) segregated from his social environment without any formal consideration to its clinical effectiveness. It was in this isolated environment that (Patient Name Redacted) spent the final hours leading up to his death.

DRC'S FINDINGS:

1) *In its sentinel event report, ASH found “Noncompliance with the 30 minute time limit for patients in the Quiet Room per hospital policy and procedure and allowing the patient to eat his meal out of sight from the staff in the Quiet Room.”³²*

DRC agrees with this finding. The failure to follow this policy as it is designed was a contributing factor to (Patient Name Redacted)’s death.

2) *ASH did not comply with ASH Policy 11.12.01 by failing to address and consider the use of the “quiet room” in (Patient Name Redacted)’s treatment plan as an appropriate and therapeutic intervention. The frequency of (Patient Name Redacted)’s presence in the quiet room was an extraordinary intervention and its clinical appropriateness and effectiveness should have been formally considered by those responsible for the development of his treatment program.*

3) FAILURE TO PROPERLY CONSIDER (PATIENT NAME REDACTED)’S PHYSICAL AND MENTAL CONDITION WHEN DEVELOPING HIS DIETARY PLAN

ASH Plan for Patient Services 2003 requires the following procedure for developing and assessing a patient’s dietary needs:

Special dietary needs are screened through the nursing admission assessment upon admission and then again by the dietary technician within seven calendar days after admission. If the screening is positive, patients are referred for evaluation to a dietitian through an order from the attending psychiatrist. Psychological, occupational therapy, and substance abuse evaluations are also available by physician order, as are referrals to external specialty medical clinics.

According to the Arkansas State Crime Lab, (Patient Name Redacted) died as a result of ‘asphyxiation, choking on bolus of food (hotdog)’ that he had consumed prior to his death. Ironically, (Patient Name Redacted) received routine dietary consults by a registered dietitian requested by his physician and underwent initial screening for dietary concerns. Throughout his numerous dietary assessments, his poor dentition was never considered.

The following excerpt is from an interview with a Registered Dietitian with ASH, who provided consults for (Patient Name Redacted):

Trevor: Okay. During the dietary food consult, do you do an assessment involving dentition?

A: We do assess chewing and swallowing problems. In his case, it would have been done during nursing assessment. They look at it and report back to me.

³² *Root Cause Analysis to Sentinel Event Report, page 3.*

Trevor: Do you recall what kind of report that you received from their team regarding his dentition and ability to swallow?

A: I don't believe that he screened out for poor dentition or poor swallowing problems.

Trevor: Is there a- do you know if there is a nurse- is there a nursing report that is submitted to you or is that a verbal?

A: When they first come on the initial nursing assessment, there is a nutrition screen at the very bottom. It's at the very bottom and it just assesses height, weight, abnormalities, chewing, swallowing problems and a few other things. If they get so many check marks, it is automatically referred to me.

Trevor: Okay, it's part of the nursing assessment then?

A: Um hum.

Trevor: And I know that the doctor also does an assessment of his own too which he addresses the dietary concerns-

A: Um hum.

Trevor: or dentition and that sort of thing. Based on the information that was provided to you and the knowledge that you had of the patient, were there any concerns about his ability to chew or swallow?

A: No.³³

Contrary to (Name Redacted) report regarding the status of (Patient Name Redacted)'s dentition, his physical examination upon admission dated July 21, 2003 indicated on page 3 of 5 that he has "**poor dentition.**" (Emphasis added.)

The resident physician that responded to the Dr. Stat, indicated in his report dated 9/3/2004 in reference to 'Sentinel Event 9/1/2004' that, "Hot dogs are the #1 most choked on food, and are not served in most "day-care" facilities because of this risk. Given the pt's poor dentition this was probably not the best meal. Pieces of food that were removed from airway ranged upwards of 1.5 inches of intact hot dog. Perhaps we should not be serving hotdogs- sounds minor but they are not a healthy food, and carry risk of choking in an environment where typical anti-psychotics are used and carry risk of laryngospasm."

³³ Registered Dietitian, Recorded Interview, February 28, 2005.

Further evidence of (Patient Name Redacted)'s dentition at the time of his death is visible in the photographs taken by the Coroner at UAMS- Emergency Room. The photographs indicate cavity-ridden teeth, poor gums, and a considerable absence of teeth.

DRC's FINDING:

ASH did not incorporate or consider the state of (Patient Name Redacted)'s poor dentition prior to assigning a diet. Per ASH's own registered dietitian as well as hospital policy, it is the hospital's responsibility to assess patients for chewing and swallowing problems, and provide an appropriate diet. However, there was no indication in (Patient Name Redacted)'s records or staff interviews that his dentition was adequately considered. Therefore, ASH clearly failed to properly follow its own policy and practice by not considering his poor dentition as a factor in his ability to consume certain types of food. This failure to consider (Patient Name Redacted)'s poor dentition contributed to his death.

4) FAILURE TO PROPERLY UTILIZE AVAILABLE STAFF AND MAINTAIN ADEQUATE STAFFING LEVELS

As indicated in the ASH Root Cause Analysis, the charge nurse was used in a dual role. Per the Root Cause Analysis, planned staffing levels for Unit 3 upper on September 1, 2004, 3-11pm shift were:

- 1 RN
- 1 Licensed Psychiatric Technical Nurse
- 1 Licensed Practical Nurse
- 2 Mental Health Workers
- 1 Ward Clerk
- 6 Total

The actual staffing for Unit 3 upper on September 1, 2004, 3-11pm shift included:

- 1 RN
- 1 Licensed Psychiatric Technical Nurse
- 1 Licensed Practical Nurse
- 3 Mental Health Workers
- 6 Total

Although staffing levels are numerically equal, the charge nurse was performing the dual role of ward clerk, who is responsible for the secretarial duties of the unit. Consequently, (Name Redacted) was distracted and unable to fully commit to her critical role as charge nurse, the staff person ultimately responsible for the operation of the unit.

The ASH Root Cause Analysis stated the following on page 4 regarding staffing for Unit 3 Upper on the 3-11pm shift for September 1, 2004:

Due to the high acuity of the patients on the unit, there was one additional nursing staff (Mental Health Worker) added to the staffing that evening. The unit,

however, did not have a Ward Clerk. The RN on duty at the time of the incident reported that she was answering the phone while watching the monitor for the patient in the Quiet Room. The unit staff were in the dining room with the other patients.

DRC's FINDING:

The staffing requirements for Unit 3 Upper were not adequately met on September 1, 2004, for the 3-11pm shift. (Name Redacted), charge nurse for Unit 3 Upper on the night in question, was responsible for performing two jobs, charge nurse and ward clerk. As a result, she was performing a dual role, which provided momentary distractions from her primary responsibility of patient care and safety.

5) FAILURE TO MAINTAIN EMERGENCY COMMUNICATION EQUIPMENT IN APPROPRIATE AREAS

Doctor reported in his statement to the ASH on September 3, 2004, regarding the 'Sentinel Event 9/1/2004 that, "Dr Stats cannot be heard in resident's room if the door is shut, this should be resolved by placement of speaker in that room."

The ASH Root Cause Analysis to Sentinel Event in reference to (Name Redacted)'s claims indicated that:

A failure mode and effects analysis had been conducted in 2003 on the "DR STAT" calls within the hospital. The responding physician noted that the "DR STAT" call was not heard in the on-call resident's room. The resident was notified of the Dr. STAT call by an employee in the admission office and there was no lag time in his response to the page."

DRC's FINDING:

Medical residents are responsible for answering Dr. Stat calls; however, there was a failure to consider the resident's room as a necessary location for an intercom. Evidence found by DRC during the course of the investigation revealed that a Dr. Stat was called at 6:45 p.m., and (Name Redacted)'s arrival on Unit 3 Upper was placed between 6:51 and 6:56 p.m., a full six to ten minutes after the Dr. Stat was announced. As a result, it is reasonable to conclude that, due to the failure to provide emergency communication equipment in the residents' room, there was a momentary delay in the response of medical personnel which may have contributed to (Patient Name Redacted)'s death.

6) VIOLATIONS OF P&A ACCESS AUTHORITY

Disability Rights Center, Inc. (DRC) is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy (P&A) System for

individuals with disabilities in Arkansas. DRC is authorized to protect human, civil and legal rights of all Arkansans with disabilities consistent with federal law.

Pursuant to the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. 15001, 15043; 45 C.F.R. Part 1386]; the Protection and Advocacy for Individuals with Mental Illness Act [42 U.S.C. 10801 et seq.; 42 C.F.R. Part 51]; and the Protection and Advocacy of Individuals Rights of the Rehabilitation Act of 1973 [29 U.S.C. 794e], the P&A System may use any appropriate technique and pursue administrative, legal or other appropriate remedy to protect and advocate on behalf of individuals with disabilities to address abuse, neglect or other violation of law.

In pursuing its statutory responsibilities, the P&A has the authority to gain access to records, facilities and individuals. In addition to its specific authority to gain access for the investigation of suspicion of abuse and neglect [45 C.F.R. 1386.22(f) and 42 C.F.R. 51.42(b)], the P&A is authorized to monitor and provide information [45 C.F.R. 1386.22(g) and 42 C.F.R. 51.42(c)]. As a general right, P&As shall have reasonable unaccompanied access to provide information, training and referrals, and to monitor compliance with respect to the rights and safety of individuals with disabilities.

DRC obtained information in late September 2004, from an anonymous source that a death occurred at ASH in a seclusion/restraint room. In an effort to substantiate this information, DRC staff Trevor Arnett and Dee Blakley met with the ASH Administrator, on September 14, 2004. (Name Redacted) was asked, “Has there been a death at ASH in a seclusion/restraint room?” (Name Redacted) responded with a puzzled look, stating “No.” He went further to claim that, “If something like that would’ve happened I would know about it.”

However, (Name Redacted) **did** know about (Patient Name Redacted)’s death. The room where (Patient Name Redacted) choked to death was a room with the dual purpose of seclusion/restraint as well as a quiet room, that is isolated from the main dayroom or patient area. DRC staff clearly expressed interest in a recent death at ASH that had been reported to DRC, not by ASH, but by an anonymous informant. (Name Redacted)’s failure to inform DRC of his knowledge of the death or to correct DRC’s use of the words “seclusion/restraint,” rather than “quiet room” only served to delay the beginning of the DRC investigation and left DRC investigators with the impression that there had been no death. Arnett and Blakley attempted to verify the information by talking to management staff from another ASH department, who said that a death had occurred – not in a seclusion room, but a quiet room.

On September 27, 2004, DRC staff Trevor Arnett briefly met with (Name Redacted). During this encounter, DRC staff requested an incident report specific to (Patient Name Redacted)’s death of September 1, 2004. (Name Redacted) responded to DRC staff by stating that the administrator had instructed her not to discuss anything regarding (Patient Name Redacted)’s death and that DRC would have to find another way to gather information. DRC advocate Trevor Arnett was directed to the hospital administrator for any questions or information regarding the incident in question. Later

that day, Trevor Arnett gained access to ASH Unit 3 Upper for the purpose of investigating (Patient Name Redacted)'s death. As part of the investigation, photographs were taken of the empty Unit 3 Upper quiet room where (Patient Name Redacted) choked to death. (Name Redacted) confronted Arnett, claiming that he would have Arnett arrested, and referred to DRC's investigative activities as 'Mickey Mouse' and 'amateur'. Furthermore, (Name Redacted) confiscated DRC's film³⁴ and claimed that Mr. Arnett would "no longer be allowed on this property without an escort... because I just don't trust you."

DRC's FINDING:

(Name Redacted) obstructed DRC's investigation by restricting access to crucial information and delayed the DRC investigation into the death of (Patient Name Redacted).

D. Recommendations

- 1) **Develop a more stringent policy** that requires documenting routine checks for patients receiving treatment on a psychiatric unit.
- 2) **Develop policy and properly train staff** to observe the respiration of patients when performing routine checks. Eliminate the use of the observation that a patient is 'sleeping' and replace it with factual observations of the patient status (i.e. 'lying down with eyes closed, respiration present').
- 3) **Enforce accountability standards** when staff fail to provide appropriate care to patients and violate ASH standard of care policies and procedures. (DRC is unaware of any disciplinary or corrective action administered to staff in relation to (Patient Name Redacted)'s death. This is disturbing because there were serious violations of policy as noted in this report and the 'Root Cause Analysis to Sentinel Event'.)
- 4) **Master treatment plans should include guidelines for appropriate therapeutic interventions** for all patients (with special attention to highly aggressive or challenging patients). Such interventions should be thoroughly reviewed and considered by the treatment team as an effective therapeutic tool for that patient. The treatment plan should also serve as a guideline for appropriate interventions available to direct care staff. Also, develop a system to address accountability of staff in providing patient care, such as means to monitor the appropriateness of treatment plans through periodic review by management or other professionals.
- 5) **Develop a comprehensive assessment for patients' diets.** Create a means to ensure appropriate communication concerning a patients diet across disciplines. Specifically,

³⁴ See *Equip for Equality Inc. v. Ingalls Memorial Hospital*, 292 F.Supp.2d, 1086, 1096. (N.D. Ill., 2003) (Illinois P&A sued for declaratory and injunctive relief regarding its right to access mental health facilities and patients at hospital located in Illinois. Court held that P&A had, pursuant to federal regulations regarding patients' rights and safety, the right to inspect, view and photograph a facility's patient areas. . .)

attention should be paid to the patient's mental status and physical condition (i.e. dentition) that might have an effect on their ability to chew or swallow; thus identifying them as high, medium, low risk for choking.

6) **Educate and train staff** on the importance of providing accurate and detailed written accounts of incidents. Establish and/or enhance a comprehensive and standardized approach to incident and witness reporting.

7) **Train staff, including administration, on the role of the Disability Rights Center as Arkansas' Protection and Advocacy System.**