

Patients in Peril 2008

A Report on Patient Deaths in 2007 and the Dangerous Medical Conditions at St. Elizabeths Hospital

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UNIVERSITY LEGAL SERVICES, INC.

Since 1996, University Legal Services, Inc. (“ULS”), a private, non-profit organization, has been the federally mandated protection and advocacy (“P&A”) program for individuals with disabilities in the District of Columbia. Congress vested the P&As with the authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. Accordingly, ULS provides administrative and legal advocacy to protect the civil rights of District residents with disabilities.

ULS staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach and education and group advocacy efforts. ULS staff addresses client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

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EXECUTIVE SUMMARY

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.” Florence Nightingale, 1859.

As a result of inexcusable lapses in the delivery of basic medical and nursing care, the health and safety of the patients at St. Elizabeths Hospital are in jeopardy. At least eleven patients died in 2007, and each death raises serious questions about the quality of medical care at St. Elizabeths. One death occurred when a staff person improperly physically restrained a patient who had both a mental illness and an intellectual disability. The staff committed significant errors in their resuscitation efforts when they noted that the patient was no longer breathing. University Legal Services, the protection and advocacy program for individuals with disabilities in the District of Columbia, conducted a thorough review of the records of the other ten patients’ deaths. The review revealed neglectful, substandard medical and nursing care, with instances of medical mistakes and appalling oversights that contributed to the severity of the patients’ illnesses, their pain and suffering, and, in some cases, perhaps even their deaths.

The records of these patients demonstrate the St. Elizabeths nursing staff’s consistent failure to perform basic, critical nursing functions. Nurses regularly fail to monitor serious medical conditions, and fail to adequately monitor and treat patients when medical problems arise. The nursing staff also fails to conduct adequate routine assessments of their patients, and there is no evidence in the records reviewed that the nurses plan and implement medically related nursing care in any meaningful way. Essential nursing responsibilities, such as the basic taking, recording and monitoring of routine vital signs, are frequently neglected, risking delayed treatment and further clinical deterioration.

Unfortunately, the records provided to ULS demonstrate that the Department of Mental Health and St. Elizabeths Hospital have only investigated five of the deaths. Even so, the Department uncovered “a chaotic nursing staff” and “serious flaws in clinical management” at St. Elizabeths. Despite its seeming awareness of these dangerous problems, the Department has been slow and inconsistent in its response, allowing patients to remain at risk.

The complete report, “Patients in Peril 2008,” details St. Elizabeths’ many significant deficiencies, and the staff’s failure to protect the patients entrusted to their care. A brief summary of the Hospital’s failures and the resulting harm follows for the eleven St. Elizabeths patients who died during 2007.

- Mr. A died on January 9, 2007, after a St. Elizabeths staff member pushed him – face down – onto the ground and placed his weight on Mr. A until he passed out during the course of a physical restraint. When staff determined that Mr. A was no longer breathing, they failed to follow basic resuscitation procedures and moved his unresponsive body across the floor. Resuscitation efforts were further

compromised because staff did not timely respond to the emergency and necessary equipment was not immediately available.

- Mr. B died on April 22, 2007, after complaining of stomach pains. The nursing staff on Mr. B's ward did not respond appropriately to his complaints, and Mr. B died of a volvulus, or twisting of the bowel, typically a very painful condition that can be treated if detected on time. Although staff indicated that they checked on him throughout the night, they found Mr. B dead in his bed, with blood stains on his sheets and "stiff with rigor mortis." Prior to his death, a registered nurse had not entered a single progress note in Mr. B's records for over three and a half months.
- Ms. C died on August 6, 2007, from an intestinal obstruction – a painful condition requiring immediate medical intervention and treatment. Ms. C complained of abdominal pain at least two days before she was taken to a community hospital, but neither the doctors nor the nurses examined her abdomen or responded to her abnormal vital signs, which were an indication that she was in medical distress. Ms. C had complained of constipation, a common side effect of psychotropic medications, but the St. Elizabeths staff failed to monitor her bowel movements. St. Elizabeths' own review of Ms. C's death found a number of policy violations that "indicate serious quality of care and practice issues, which require immediate supervisory corrective action, review and determination."
- Mr. D died on October 10, 2007, due to acute renal failure. While at St. Elizabeths, Mr. D experienced two episodes of lithium toxicity – one, in 2006, that resulted from a medication administration error causing him to receive an excess of his scheduled daily doses. Despite exhibiting symptoms of toxicity in the days preceding hospitalization in the community, St. Elizabeths staff inexplicably delayed in sending him to the hospital. As a result of his toxic condition, Mr. D was hospitalized for three months and developed extremely serious, life-threatening complications, from which he never fully recovered. He returned to St. Elizabeths with multiple bed sores, which the nurses failed to assess and monitor adequately. In 2007, he was again taken to a community hospital. On arrival, he was in critical condition from an extremely infected state known as sepsis. His temperature was 85 degrees, his abdomen was large and distended from not being able to urinate, and his pulse rate was very low. During the days prior to this admission, the nurses and the medical staff at St. Elizabeths did not respond adequately to his complaints of pain, nor did they adequately monitor his vital signs and temperature.
- Mr. E died on October 27, 2007. In March 2007, Mr. E had suspected drug-induced Parkinsonism and was hospitalized at George Washington Hospital, where the staff discontinued all psychotropic medications because of concerns that he was experiencing Neuroleptic Malignant Syndrome ("NMS"), a very serious, life threatening condition caused by psychotropic medications. Although the St. Elizabeths staff resumed prescribing multiple psychotropic medications, the nursing staff failed to monitor Mr. E for symptoms of these conditions

adequately, even after the doctors suspected a recurrence of the NMS, which required another hospitalization. In May 2007, the St. Elizabeths staff inexplicably prescribed a medication for Mr. E that a consulting physician had recommended discontinuing due to Mr. E's adverse reaction to the medication, including its adverse effect on his ability to walk. Nevertheless, Mr. E received this medication for almost two months. As with the other patients who died, the nursing staff failed to adequately monitor Mr. E's serious medical conditions, including pneumonia, chest pains, and continued risk of falling, and failed to monitor his weight despite a significant weight loss and his doctor's note of "malnutrition." Mr. E was admitted to a community hospital in October 2007 with intestinal problems and pneumonia, where he ultimately died. Again, the nurses failed to adequately address the signs of clinical decline that Mr. E exhibited in the days prior to his final hospitalization.

- Mr. F died on December 6, 2007. He was well known to St. Elizabeths Hospital and had been admitted multiple times since 1980, with his most recent admission in March 2007. During his final eight-month stay, Mr. F was exposed to substandard medical and nursing care, required multiple hospitalizations, and experienced a significant decline in his clinical condition that resulted in his death. Despite warnings from consulting physicians that antipsychotic medication should be avoided due to Mr. F's extreme sensitivity to them, the Hospital inexplicably continued to prescribe them. As a result, Mr. F exhibited symptoms of a severe reaction and required repeated hospitalization. The Hospital also failed to implement recommended behavior management efforts in any meaningful way. As with the other deaths, Mr. F's treatment at the Hospital raises serious question about basic nursing assessments, planning and treatment, particularly when he exhibited symptoms of an acute clinical decline. In addition, his records contain evidence that staff inaccurately recorded, if not fabricated, the administration of medication to Mr. F while he was actually hospitalized in the community, and not at St. Elizabeths.
- Mr. G died on September 29, 2007, due to chronic liver disease. Despite his multiple medical conditions and deteriorating health, including weakness, dehydration, lack of urine output and severe nose bleeds, and after the doctors noted that Mr. G was "critically ill," the nursing staff failed to conduct necessary monitoring and assessments. Although Mr. G knew that he was dying, St. Elizabeths staff provided him no meaningful end-of-life planning.
- Ms. H died on July 17, 2007. The nursing staff at St. Elizabeths failed to monitor a number of serious medical conditions, including lung disease, congestive heart failure, and chronic, excessive diarrhea; her last physical examination was almost a year before she died. Despite ongoing life-threatening medical concerns, regular low blood pressure and high pulse readings, and significant weight loss, the nurses at St. Elizabeths failed to respond adequately to the abnormal vital sign readings and failed to conduct assessments of her medical condition. Also, the nurses did not make a single note about Ms. H's condition in her records for the

two weeks before she was taken to Washington Hospital Center, where she later died.

- Mr. I died on July 4, 2007, of cardiopulmonary arrest. Mr. I was suffering from a number of serious, debilitating medical problems, yet St. Elizabeths staff failed to monitor and treat these conditions adequately. The nursing staff did not develop or update a nursing care plan that addressed Mr. I's medical problems, did not regularly assess his conditions, and often failed to inform Mr. I's doctor of complaints he had or changes in his condition, including ongoing difficulty breathing and chest pain. The Hospital staff also failed to engage Mr. I in any meaningful end-of-life planning, in spite of his chronic illnesses.
- Mr. J died in June 2007, of end stage renal disease after suffering cardiac arrest. Despite multiple serious medical conditions, the nursing staff at St. Elizabeths failed to conduct routine nursing assessments or monitoring. More troubling, when Mr. J exhibited symptoms of clinical decline, such as having difficulty breathing or walking, the nurses failed to assess and monitor his condition.
- Mr. K died sometime in October 2007, while he was on leave from St. Elizabeths. Although Mr. K had numerous medical problems, including chronic obstructive pulmonary disease and a positive tuberculosis test, the nursing staff had not performed an annual nursing assessment since 2003. Mr. K experienced multiple troubling symptoms, including low blood pressure, dizziness, elevated temperature and not having a bowel movement for up to five days, but the nursing notes were sparse, did not contain adequate assessments and did not address his concerns appropriately. ULS did not receive any records explaining the ultimate cause of his death.

INTRODUCTION

More than three years ago, in November 2004, University Legal Services, the protection and advocacy program for individuals with disabilities in the District of Columbia, published “Patients in Peril: A Report on the Dangerous and Substandard Care at St. Elizabeths Hospital.” That report began: “The patients and staff at St. Elizabeths Hospital, the District of Columbia’s only publicly operated psychiatric hospital, face serious risks to their health and safety everyday. Many conditions contribute to these dangers, including but not limited to:

- overcrowded wards
- inadequate clinical staff
- insufficient medical resources
- overworked and demoralized staff
- deficient quality assurance/improvement efforts
- inefficient mechanisms for discharging consumers to community-based alternatives
- substandard physical conditions.”

While the census at St. Elizabeths Hospital (“St. Elizabeths” or “the Hospital”) has declined slightly in the last three years and wards are not as routinely overcrowded,¹ none of the other six conditions have been improved in any significant way.² In fact, the quality of medical services appears to have deteriorated further, placing patients at continued risk.

In 2007, at least eleven patients died at St. Elizabeths.³ Widely publicized, the first patient died in the course of a physical restraint episode that raised numerous concerns about staff competency, particularly the dangerous manner in which a staff person restrained the patient, and botched resuscitation efforts with no evidence that a registered nurse participated in them directly. A review of the remaining ten patients’ medical records suggest that they died of medical causes, and reveal alarming deviations from standard practices in the delivery of medical care. One patient, who died of a twisted bowel, was found dead in his bed, his body already stiff with rigor mortis. The nursing staff did not address the patient’s complaints of abdominal pain the night before he died, and a doctor never examined him. Similarly, another patient who died of a bowel obstruction complained of abdominal pain two days before her death, yet the medical records contain no evidence that nurses or doctors performed an abdominal assessment. When staff finally sent the patient to a community hospital, her condition had become unstable, and she ultimately died.

Other patients were also the victims of staff incompetence. One patient mistakenly received an excessive dose of his medication resulting in a three-month hospitalization, serious complications and permanent harm. Six months later, the same patient, inadequately monitored, deteriorated to the point of being in critical condition with a body temperature of 85 degrees before the St. Elizabeths staff sent him to a community hospital. Another patient’s medication was discontinued after causing

serious side effects, yet it was mistakenly prescribed again, without explanation, placing the patient at risk of serious complications. Similarly, a different patient was prescribed antipsychotic medication, despite consulting physicians' warnings that the patient had a history of severe reactions to the medications and consultants' questions about their effectiveness, given his clinical presentation. And yet another patient with multiple, serious medical conditions, including late-stage HIV disease, spent up to 25 days in medical isolation without a plan to address the extreme seclusion of being confined to his room. Several patients had multiple instances of notably abnormal vital signs, which should have alerted the staff to take action or at the very least monitor the patient more closely, yet the readings appeared to have been ignored. Also, several patients were not taken to the emergency room until hours after doctors ordered their immediate transport.

ULS reviewed the deceased patients' medical records and discovered significant deficiencies in medical and nursing care.⁴ In every single death, the medical records contain little or no evidence that the nursing staff at St. Elizabeths is performing basic, critical nursing functions. "The nursing process is a deliberate, problem solving approach to meeting the health care and nursing needs of patients." *Manual of Nursing Practice 5* (Lippincott, Williams & Wilkins ed., 8th ed., 2006). The essence of nursing care includes assessment, diagnosis, planning, and implementation and evaluation of care. Not only are these steps crucial to ensure patients' safety and well-being, the District of Columbia's Registered Nurse ("RN") licensing regulations require them.⁵ The medical records of the deceased patients reflect that this vital nursing process is not occurring in any meaningful way, and that medical and nursing staff are not consistently addressing, monitoring and treating medical problems as they arise. In particular, the RNs at St. Elizabeths are not assessing patients' medical conditions adequately. A nursing assessment is a "systematic collection of data to determine the patient's health status and to identify any actual or potential health problems" and includes a nursing history and a physical examination. *Id.* In the medical records of the deceased patients, however, the nursing "assessment" is haphazard and often incomplete. Furthermore, the nurses are not adequately planning and implementing nursing care nor are they effectively monitoring their patients' medical conditions. The nursing staff is neglecting even such fundamental responsibilities as monitoring patients' vital signs. In addition to poor nursing care, ULS uncovered examples of medical oversights and substandard medical care. Neglect⁶ in so many aspects of care and treatment creates an intolerably precarious situation for the patients at St. Elizabeths Hospital.

The District is well aware that the nursing and medical care at the Hospital is woefully inadequate. The Department of Mental Health's investigation of the death in April 2007 found "a chaotic nursing staff with no clear understanding of who was in charge of making clinical decisions" and "serious flaws in clinical management." And the Hospital's own investigation of a death in August 2007 found "serious quality of care and practice issues, which require immediate supervisory corrective action...." It goes without saying that substandard medical and nursing care places the already vulnerable patients at St. Elizabeths at even greater risk, and this neglect has already resulted in needless pain and suffering, and may well have contributed to deaths from treatable conditions.

Despite repeated promises of reform since 2004, the District has been slow and inconsistent in its response. Hospital initiatives are started and stopped without explanation. Staff hired to fill critical vacancies and focus on quality improvement leave. In settling litigation threatened by the United States Department of Justice (“DOJ”), the District agreed to make changes over a three year period of time – changes that need to be made immediately. In a recent report about the Hospital to the DOJ, the District admitted that “there are fundamental infrastructure issues that are adversely affecting quality of care across the board . . .” including “training, leadership and quality improvement.” These fundamental infrastructure issues are not new.

In fact, it appears that 2007 saw an increase in the number of St. Elizabeths patients who died. Although ULS has asked the District for all documents related to every death at the Hospital since 2003, it only provided ULS with a list of the names of seven people for whom it had performed mortality reviews in 2004, seven in 2005, and four in 2006. Despite the Hospital’s repeated promises of reform, as many patients died in 2007 as the previous two years.

THE PATIENTS

Mr. A, Died January 9, 2007

On January 9, 2007, Mr. A, a 39 year-old patient with mental illness and an intellectual disability, died after being physically restrained by a mental health counselor. The Office of the Chief Medical Examiner determined that the manner of Mr. A’s death was “homicide.” The Department of Mental Health (“DMH”) conducted a death investigation and quality improvement review that found a number of troubling deficiencies, particularly around the manner in which the staff person conducted the restraint. Two witnesses reported that the mental health counselor “grabbed” Mr. A in order to “take him down,” and witnesses provided contradictory statements about whether Mr. A had been placed in a prone – face down – position, in violation of Hospital policy. Witnesses also provided inconsistent reports about whether the mental health counselor sat, lay or halfway lay on Mr. A during the restraint. Although the witnesses agreed that Mr. A appeared “lifeless,” staff also attempted to raise him to his feet, and, when they were unsuccessful, “dragged” him a short distance to have more room for resuscitation efforts. This move would be absolutely contraindicated if there were any suspicions that Mr. A had suffered a neck or head injury.

The investigation also contained several other alarming findings. Two female psychiatric nursing assistants were present during the episode but chose not to participate or provide assistance. No Hospital staff responded to the first Code 13 (for a psychiatric emergency) and when staff did respond to the second Code 13, they were untimely. From the Department of Mental Health’s investigation, it appears that a registered nurse did not respond to either of the Code 13’s, and although she “responded” to the Code Blue (for a medical emergency), she was sent to find oxygen equipment and did not participate in the initial resuscitation efforts. Also, because she was not the RN who

retained the key for the closest oxygen closet, the Hospital's Chief Executive Officer, Patrick Canavan, had to unlock one oxygen closet after arriving on the ward while staff ran to Employee Health to obtain other oxygen units. Inexplicably, one oxygen unit did not function properly.

Mr. B, Died April 22, 2007

During the evening hours on April 21, 2007, Mr. B, a 56 year-old patient at John Howard Pavilion, the forensic division of St. Elizabeths Hospital, complained of stomach pain. The next morning, the nurse on the ward found Mr. B dead in his bed "stiff with rigor mortis," with signs of gastric bleeding on his bed sheets. According to the Department of Mental Health's death investigation, Mr. B's death was associated with a volvulus, or twisting of the bowel, with necrosis, or gangrene of the bowel. Volvulus is life-threatening, requires immediate attention, and is typically very painful.⁷ If a patient with volvulus receives timely intervention, the condition can be treated effectively with close observation and/or surgery.⁸

The nurse on duty the evening before Mr. B died did not write an entry in Mr. B's progress notes about his complaint of abdominal pain or any nursing response, in violation of Hospital policy and general nursing practice. There are no RN progress notes indicating that staff took Mr. B's vital signs or that the RN completed any type of assessment of his patient. In fact, there is not a single progress note written by any staff member on April 21, 2007, the night of Mr. B's death, when he probably experienced extruciating pain. Disturbingly, there are no RN notes in the records from January 5, 2007, to April 22, 2007, when the RN wrote a progress note *after* Mr. B was discovered to be dead. Furthermore, in the course of the Department of Mental Health's investigation, the nursing staff on duty the night before Mr. B died provided conflicting reports about whether the basic nursing function of taking vital signs was even performed.

The Department of Mental Health's death investigation noted grave concerns about the general medical and nursing care Mr. B received prior to his death:

The events surrounding Mr. B's death at St. Elizabeths Hospital reflect serious concerns about the overall system of medical processes and treatment coordination at the Hospital, as evidenced by the following: conflicting staff reports as to onset of symptoms, yet no medical record documentation; two significantly varying recollections of Mr. B's vital signs on April 21, 2007, with no medical record documentation of either of the reported values; a chaotic nursing staff with no clear understanding of who was in charge of making clinical decisions; a clear lack of clinical response to Mr. B's complaints of abdominal pain; and a system of superficial bed checks that indicated Mr. B present in bed at a time that he was already dead, and when there were visible sign[s] of gastric bleeding on his bed linens. It is clear that there is a significant gap in both nursing and physician leadership at St. Elizabeths. (Emphasis added).

In addition, the DMH investigation raised concerns about the Hospital's over-reliance on overtime staffing and how it played a role in Mr. B's death, and the possibility that staff fatigue adversely affected decision-making. All of the nursing staff who were working during the shift when Mr. B died were either working the second half of a double shift, had just completed a double shift in the past twenty-four hours, or were coming back to start a double shift. DMH also noted that the absence of a clear delineation of authority and responsibility between registered nurses and licensed practical nurses may have contributed to the Hospital's missteps in responding to Mr. B's condition.

The Hospital's medical records for Mr. B before he died also reveal significant and serious deficiencies related to nursing and medical care at the Hospital. Most notably, as previously mentioned, his records do not contain a single progress note signed and initialed by a registered nurse or licensed practical nurse ("LPN") from January 5, 2007, until he was found dead on April 22, 2007. Similarly, the flow sheets for recording vital signs do not have any vital signs recorded during the months of February and March 2007. The notes contain only one recorded set of vital signs for April 2007, although the day itself appears to be redacted with "white out." That day, his blood pressure was 190/82, an extremely high reading when compared to previous readings for Mr. B.

Mr. B's records also reveal that he was being prescribed multiple psychotropic medications, yet there is no evidence that he was being monitored for the serious side effects associated with these drugs.⁹ In fact, on February 6, 2007, the attending psychiatrist noted that Mr. B complained of feeling "over-sedated," but there are no subsequent progress notes that address this complaint. Not surprisingly, in its investigation, DMH found that the Hospital did not have a standard practice for managing multiple psychotropic medications. And, when interviewed, the Assistant Director of Nursing at the Hospital wondered whether Mr. B had been over-sedated as a result of his medications and, therefore, his abdominal symptoms were muted.

Ms. C, Died August 6, 2007

Ms. C died unexpectedly on August 6, 2007. Although she was only 59 years old, her diagnoses included hypertension, dementia, asthma, urinary incontinence and Parkinsonism. The D.C. Office of the Chief Medical Examiner's preliminary finding for the cause of death was intestinal obstruction, a life-threatening condition that requires immediate medical intervention.¹⁰ Intestinal obstruction typically manifests with abdominal pain, nausea and vomiting.¹¹ According to the records provided to ULS, Ms. C complained of abdominal pain two days before being transported to the community hospital where she died, but incredibly, neither the General Medical Officer ("GMO") nor the nursing staff at the Hospital ever performed an abdominal assessment or examination.¹² In addition, the records indicate that two days before her transfer, Ms. C had an elevated pulse rate (tachycardia), which is also a symptom of bowel obstruction.¹³ On August 3, 2007, and August 4, 2007, Ms. C's pulse was recorded on the vital sign sheet as elevated to 123 beats per minute.¹⁴ Even so, her pulse rate was not recorded in

the progress notes; those notes also contain no evidence that the GMO or a nurse evaluated Ms. C after learning of the elevated pulse rate.

Like most patients at the Hospital, Ms. C was prescribed antipsychotic medications¹⁵ that placed her at increased risk of constipation, which is associated with bowel obstruction and is a common side effect of antipsychotic medications.¹⁶ The medical records contain documented instances when Ms. C complained of constipation, yet the records do not contain evidence that the staff followed up appropriately. Although prescribed laxatives, the records do not indicate clearly whether Ms. C ever had a bowel movement in response. And despite her complaints of constipation and the administration of laxatives, the medical records contain no reference to, or evidence of, the staff monitoring Ms. C's bowel movements, an appropriate and necessary clinical response.

In response to Ms. C's death, St. Elizabeths conducted an internal investigation. In its investigation report dated August 22, 2007, the Hospital found "a number of violations of policy and professional standards of care, as well as, areas where treatment and practice could be improved." The report concluded: "[T]hese findings indicate serious quality of care and practice issues, which require immediate supervisory corrective action, review and determination." Among other things, the internal investigation found that: the GMO failed to document an abdominal examination on the days prior to Ms. C's death (although after her death he claimed to have done one); the GMO had not conducted an annual medical examination since 2005; Ms. C had medical conditions for which she was not receiving treatment; her heart rate ranged from 103 to 123 seven out of ten days before her death; progress notes usually attributed her nose bleeds and swollen feet to "picking her nose" and "tight socks;" the psychiatric nursing assistant ("PNA") did not inform the charge nurse of Ms. C's abnormal blood pressure reading of 147/104 at 4:00 p.m. on the day before she died; and there was a one hour and twenty minute delay in the nursing request for 911 transport to the emergency room after the GMO ordered that she be transferred. The investigation report also contains a statement from a PNA that "Ms. C had been feeling badly, 'up and down' for two weeks (2) weeks" prior to her death. Yet between July 17, 2007, and August 3, 2007, the progress notes do not contain a single entry by an RN about Ms. C's condition.

ULS' review of the medical records revealed multiple instances when Ms. C exhibited signs of a change in medical condition, including nose bleeds, swelling in her face, legs and feet, weakness, and rashes and lesions, without documented nursing assessments, treatment and follow-up. Large gaps in RN documentation exist in Ms. C's progress notes. For example, the progress notes contain only two RN notes for June 2007 and two RN notes for July 2007, despite significant changes in Ms. C's condition during that time. Finally, there is no evidence in the medical records that nursing staff were monitoring Ms. C for potentially dangerous side effects of the multiple psychotropic medications she was prescribed. As part of an initial assessment shortly after her admission in July 2005, the Hospital staff conducted an AIMS assessment,¹⁷ but the records contain no further evidence that she was being monitored for medication side effects.

Finally, ULS did not receive any records to show that DMH conducted its own investigation into Ms. C's death, even after the Hospital's investigation found "serious quality of care and practice issues." By failing to follow up and demand corrective action following such a finding, especially given the Hospital's history, the Department of Mental Health ignored its responsibility as the District's Mental Health Authority to ensure proper care and treatment at the Hospital.

Mr. D, Died October 10, 2007

Mr. D died on October 10, 2007, at the age of 64, the victim of medical missteps and substandard nursing care, leading to life-threatening conditions and serious complications requiring hospitalizations for extended periods of time.

Mr. D had been a patient at St. Elizabeths Hospital since 1979, and was diagnosed with bipolar disorder, diabetes, drug-induced diabetes insipidus, prostate hypertrophy and acute renal failure secondary to obstructive uropathy, and had a history of tardive dyskinesia.¹⁸ As with the other patients who died in 2007, ULS' review of Mr. D's records reveals evidence of a disturbing pattern of medical mistakes, including the staff's failure to adequately note symptoms and respond to serious clinical conditions, and the nurses' failure to perform basic and essential nursing functions. The records also reveal that a licensed physical therapist was not available when intensive physical therapy services were recommended, and that Mr. D was not adequately monitored when one, or even two, staff persons were ordered to be within arm's length at all times. Despite Mr. D's extensive medical problems, the records did not contain a nursing care plan or nursing assessment for either 2006 or 2007. To implement a nursing plan, the nursing staff must coordinate the activities of the treatment team, supervise the performance of the nursing interventions, and "record[] the patient's responses to the nursing interventions precisely and concisely." *Manual of Nursing Practice 7* (Lippincott, Williams & Wilkins ed., 8th ed., 2006). None of this happened for Mr. D.

Staff at St. Elizabeths mistakenly gave Mr. D multiple doses of lithium, and then failed to respond promptly when he began to exhibit symptoms of toxicity. According to a psychopharmacology consultation dated July 28, 2007, Mr. D experienced two episodes of lithium toxicity, and that "most recently, he required medical treatment after developing [diabetes insipidus] *following miscommunication amongst the prescribing staff and multiple doses that exceeded his scheduled daily dose.*" (Emphasis added). This medication error caused Mr. D to be admitted to Greater Southeast Community Hospital in November 2006, and transferred to Georgetown University Hospital on December 12, 2006, where he stayed for *three months* with a diagnosis of diabetes insipidus from lithium toxicity.¹⁹ During this extensive hospitalization, Mr. D developed pneumonia, a urinary tract infection, sepsis and two decubitus ulcers (bed sores), as well as MRSA, a drug-resistant bacterial infection.

Not only did the Hospital's errors cause Mr. D to become lithium toxic, the records reveal that the Hospital failed to act in a timely manner when Mr. D first began

exhibiting symptoms of the toxicity. On November 26, 2006, and November 27, 2006, Mr. D was noted to be “confused, agitated” “drowsy but arousable,” and “unsteady on his feet.” Over the next three days, Mr. D continued to show symptoms of lithium toxicity²⁰ and on November 28, 2006, the psychiatrist noted that Mr. D “continues to have tachycardia and rigidity” and that his lithium level “was quite high this morning.” Despite these findings, the Hospital staff did not have Mr. D transported to the community hospital until the next day.

In June 2007, the Hospital staff once again failed to adequately monitor Mr. D when he was experiencing a serious, potentially life-threatening condition, and again failed to take action in a timely manner once they detected the condition. When Mr. D arrived at Greater Southeast Community Hospital on June 6, 2007, his abdomen was “large” and “distended” (from a urinary obstruction), his temperature was 85 degrees and his pulse was low. He was transferred to Georgetown Hospital and diagnosed with obstructive uropathy (inability to urinate)²¹ and sepsis. His inability to urinate necessitated the placement of a suprapubic catheter.²² Mr. D remained hospitalized for six days.

Progress notes from the days preceding the hospitalization show a disturbing lack of monitoring of Mr. D’s deteriorating condition. No vital signs are recorded on the flow sheet or in the progress notes for June 3, 2007, through June 5, 2007. The records show that early in the morning on June 6, 2007, Mr. D complained of pain and swelling to his groin. A progress note timed at 9:00 a.m. states that Mr. D “would periodically yell out for a nurse or doctor to examine him . . . Patient was seen by [D]octor Woo for examination of groin.” The records do not contain a note indicating that Dr. Woo actually saw Mr. D for these symptoms, and the records do not contain vital signs or an RN assessment. An RN progress note timed at 3:00 p.m. the same day noted that Mr. D’s pulse was very low at 52, although no temperature was recorded, and that he was “less active all day long.” The records contain no indication that the nursing staff informed the General Medical Officer (“GMO”) of these concerning symptoms.²³ Mr. D was seen by the doctor that evening and transported to the hospital at 6:05 p.m., but by then, according to the doctor’s note, his temperature was 85 degrees, and he was “disoriented,” and “rigor” was noted. Even then, the RN note does not include a temperature reading or evidence of an assessment. It is not clear from the records how long Mr. D had gone without being able to urinate, but it is clear that he arrived at the hospital with a distended abdomen and that the urinary retention was severe enough to cause serious infection.

Mr. D was again hospitalized from June 20, 2007, to July 10, 2007. Here too the records raise questions as to whether the nurses adequately monitored his condition prior to this hospitalization. Although a forensic psychiatric technician (“FPT”) noted that Mr. D’s temperature was elevated in the afternoon of June 19, 2007, and the vital sign flow sheet indicates that it was elevated in the morning of June 20, 2007, the records contain no RN notes referencing the elevated temperature.²⁴ Mr. D was admitted to the hospital at 5:30 p.m. on June 20, 2007, was diagnosed with urosepsis,²⁵ and required a blood transfusion.

In addition to the staff failures noted above, the records are replete with examples of the nursing staff failing to adequately assess Mr. D's medical conditions, and failing to plan and implement care. For example, nursing staff failed to adequately assess and monitor Mr. D's decubitus ulcers. Despite indications of infection and orders for daily dressing changes,²⁶ the nursing progress notes rarely state the size of the ulcers, what stage they were at and whether signs of infection were present.²⁷ In the rare instance when the nurses noted signs and symptoms of infection, there is no indication that they notified the doctors or performed adequate follow-up.²⁸ The nurses failed to document whether an infection was present even though, on April 2, 2007, the GMO wrote that staff "need[s] to be able to detect infection early, [because patients with] MRSA septicemia have a greater chance of recurrent septicemia." Despite being assigned one-to-one staffing, Mr. D frequently removed his dressings, thereby exposing the ulcers to further infection. For example, on April 9, 2007, a GMO note states "[patient] keeps removing the dressing, the wound was found uncovered and was exposed to fecal material"

The records also reveal that there were instances when Mr. D experienced other changes in clinical condition, such as an elevated blood glucose level, a low blood glucose level, and/or constipation, yet the records contain no indication that the nurses consistently assessed or monitored him to ensure that his condition had stabilized. As was the pattern with other patients, there were large gaps in the recording of vital signs (e.g., no vital signs recorded on the flow sheet from April 21, 2007, to June 1, 2007) and incidents when abnormal vital signs were recorded, yet the records did not contain corresponding nurses' notes or evidence that the nurses notified the GMO. In addition, despite orders for monthly weight monitoring, the records provide no evidence that the staff weighed Mr. D for almost four months, from April 20, 2007, to August 16, 2007, when he was noted to have lost almost thirty pounds.

In addition, although Mr. D was diagnosed with drug-induced tardive dyskinesia, the records contained only one undated AIMS assessment to monitor for side effects from the multiple psychotropic medications he was prescribed.

The records also raise questions about the Hospital staff's monitoring and treatment of Mr. D's behaviors, which placed him at risk of self-injury. Even though at least one, and sometimes two, staff were required to be within arm's length of Mr. D at all times, the records indicate that Mr. D pulled out his suprapubic catheter at least five times (requiring emergency room treatment), frequently stood in the shower with his clothes on for up to eight hours at a time, and drank his own urine. In at least one instance, the Hospital staff placed Mr. D in leg restraints despite the doctor's specific order that leg restraints not be used. Mr. D's family questioned how he was allowed to do these things while he was supposedly being monitored. In a letter to the Associate Director for Medical Affairs, they wrote: "In reviewing our father's medical records, we noted many of the injuries he claim[ed] have not been explained in his records. While some injuries are noted, but not explained, others are not noted at all. Yet we see evidence of such injury(s). Please explain."²⁹

Although the Department of Mental Health obtained a psychopharmacology consultation for Mr. D, it appears that the Hospital failed to heed its recommendations. The consultation, dated July 28, 2007, recommends that in addition to medication treatment, the doctors at St. Elizabeths consider implementing a “systemic strategy to assess and track the patient’s mood rating, medication response and side effects on a daily basis.” The consultation included a specific example of a tool that could be used to accomplish this, as well as a detailed discussion of how and why the tool would be helpful. In addition, the consultation recommended a daily exercise program “to help modulate mood, reduce anxiety and agitation, maintain body weight and discharge excess energy constructively...[and] help build structure in to Mr. D’s day.” There is no indication in Mr. D’s records that the Hospital staff implemented any of these recommendations.

Similarly, staff never followed through on a doctor’s recommendation for a physical therapy evaluation. On March 20, 2007, a GMO note states that Mr. D was “[a]lmost confined to wheelchair, barely able to transfer himself from wheelchair to bed . . . needs . . . [a] PT evaluation.” Three days later, a GMO note states that Mr. D “[s]hows extreme weakness of lower extremities. . . . Will need intensive PT/OT [physical therapy/occupational therapy.]” The records indicate that it was not until August 21, 2007, that the physical therapy assistant attempted to evaluate Mr. D, only to discover he was hospitalized at the time. Another brief note states that the physical therapy assistant came to evaluate Mr. D, but Mr. D refused the evaluation. There is no indication that anyone ever explained the importance of the physical therapy to Mr. D.

In 2004, ULS reported that physical therapy services were not available to the patients at St. Elizabeths, even when doctors documented the need for physical therapy services. ULS noted that two patients who likely died of a blood clot to the lungs had not received physical therapy services designed to prevent such blood clots. Although the current records reveal that a physical therapy assistant is now assigned to some patients at the Hospital, there is no evidence that a licensed physical therapist is available, even for patients like Mr. D, who have a documented need for such services.

Mr. D received extremely poor care at St. Elizabeths Hospital before he died. The Hospital knew it, as did his family. In their letter to the Associate Director of Medical Affairs at the Hospital, Mr. D’s family wrote: “It seems you medicate him, seclude him, take notes and complain of his reaction – you do no more and no less.”³⁰

Mr. E, Died October 27, 2007

Mr. E was 59 years old when he died on October 27, 2007, having been transferred to a community hospital ten days earlier. He had been in and out of St. Elizabeths Hospital for more than twenty years, having been first admitted at the age of nineteen. He was admitted for the last time more than two years before his death. In reviewing Mr. E’s medical records, ULS found that while he was a patient at St. Elizabeths, Mr. E was a victim of substandard medical care that caused preventable harm and placed him at unnecessary risk.

Like many of the other patients who died in 2007, the medical care that Mr. E received at St. Elizabeths was well-below acceptable standards. In March 2007, Mr. E was hospitalized at George Washington Hospital for pneumonia. Staff there discontinued Mr. E's antipsychotic medications due to concerns that he had developed Neuroleptic Malignant Syndrome ("NMS"),³¹ a life-threatening condition caused by psychotropic medications. Eventually, St. Elizabeths Hospital staff placed Mr. E back on multiple psychotropic medications, yet there is no evidence in the medical records that the nursing staff adequately monitored him for possible side effects.³² Even when the doctors sent Mr. E back to a community hospital on September 7, 2007, suspecting a reoccurrence of NMS after nurses found him at the piano, "stiff, fist clenched to his face and grunting and drooling," the progress notes do not contain evidence that the nurses routinely monitored Mr. E for recurring symptoms of NMS or monitored his fluid intake to avoid dehydration, which would be indicated.³³ Neither the nursing progress notes nor the nursing care plans of August 2006 and February 2007 contain any mention of Mr. E's NMS diagnosis. Similarly, the most recent AIMS assessment for psychotropic medication side effects in Mr. E's medical records is dated July 6, 2006.

In addition, Mr. E was mistakenly prescribed a particular antipsychotic medication (Valproate) for almost two months even though the neurologist at the Hospital had specifically recommended that it be discontinued due to its adverse effects of motor dysfunction, including an unsteady gait, which resulted in multiple falls for Mr. E. The medical records indicate that Valproate was tapered and discontinued in December 2006, at the neurologist's recommendation. A neurology follow-up consultation dated February 14, 2007, states that Mr. E had "a significant improvement in motor function after the discontinuation of the Valproate," and recommended that Valproate be avoided because Mr. E had an adverse reaction to it. However, the medication was inexplicably restarted on May 24, 2007,³⁴ and Mr. E continued to receive the Valproate until the doctors discovered the error in July 2007. Only then was he again tapered off of the medication. During the time Mr. E mistakenly received the medication, his unsteady gait worsened and he experienced at least two falls, one resulting in sutures to his head.

The medical records contain no evidence that the nurses routinely assessed Mr. E for symptoms of a head injury or monitored his mental status after his many falls. Despite medical orders for a staff person to remain within arm's length due to a high risk of falls, the records suggest that staff did not always follow this order. For example, on May 8, 2007, Mr. E was "*found* by a staff person" to have a laceration to his head requiring stitches.³⁵ (Emphasis added). During the last month of his life, the medical records indicate that Mr. E's condition was worsening, and his behavior became much more challenging. Somehow, despite continual doctor's orders for a staff person to remain within arm's length at all times, Mr. E exhibited extreme behaviors such as eating his diaper, eating trash and smearing feces on the wall. On one occasion, Mr. E attacked a staff member, attempting to leave the ward. The records note that his assigned one-to-one staff person had left Mr. E alone.³⁶

Mr. E was diagnosed with multiple medical conditions, including pneumonia, multiple episodes of low blood pressure, chest pain and arm and foot cellulites, which the nursing staff did not adequately assess and monitor. The nurses' progress notes contain very few entries documenting an adequate physical assessment when these conditions occurred. Moreover, the annual nursing assessment, dated February 15, 2007, contains no assessment of Mr. E's many medical conditions, and the attached nursing care plans are very brief, do not address any of his medical diagnoses, and were not updated as his clinical condition changed. During the last months of his life, Mr. E frequently experienced low blood pressure (as low as 86/62), yet the medical records contain no corresponding nurses' notes, provide no indication that the nursing staff notified the doctor,³⁷ and rarely contain recorded follow-up blood pressure readings. Similarly, the monthly GMO notes are very brief, typically merely restate Mr. E's medical diagnoses, and rarely indicate that the doctor physically examined him. Due to the psychotropic medications he was prescribed, Mr. E was also at risk for constipation,³⁸ which can lead to more serious bowel disorders. In fact, Mr. E was diagnosed with an intestinal ileus (a bowel disorder)³⁹ and pneumonia during his final hospitalization. However, the medical records contain no evidence, that the nurses or doctors at St. Elizabeths routinely monitored Mr. E's bowel movements.

In the last year of his life, Mr. E experienced a twenty-five pound weight loss in a three month period, yet the nursing progress notes did not include any mention of weight loss and the doctor's orders only required "monthly weight." The doctor's physical exam on August 20, 2007, noted "malnutrition," yet this diagnosis was not adequately addressed in the nurses' progress notes nor mentioned in the nursing care plan, and, even then, the doctor only ordered a monthly weight for September 2007.⁴⁰

On October 10, 2007, Mr. E vomited his meal after dinner. At 3:00 a.m., he began to vomit again and was noted to have a fever. He was sent to a community hospital to rule out a bowel obstruction and returned to St. Elizabeths Hospital on October 15, 2007. The transfer summary from the hospital states that Mr. E was diagnosed with pneumonia.⁴¹ Upon his return to St. Elizabeths, it does not appear that a medical doctor examined him, nor did an RN adequately assess his condition. For the next two days, staff documented in the progress notes that Mr. E was weak, had a significant decrease in appetite and was not eating most of his meals. The progress notes also indicate that his hands were swollen and later noted swelling in the feet and legs. Another note stated that staff "noticed his stomach was swollen." Nevertheless, no vital signs were recorded on the vital sign sheet from October 15, 2007, through October 17, 2007. The blood pressure readings in the progress notes for October 16, 2007, indicated that Mr. E's blood pressure was low. Despite these concerning symptoms, the medical records do not demonstrate that the nursing staff notified a medical doctor or that a doctor examined Mr. E until he was noted to be vomiting on October 17, 2007, and he went to the hospital for the final time, where he was diagnosed with pneumonia and an intestinal ileus.

The Hospital clearly failed to address serious needs in Mr. E's care before he died. Nevertheless, the Department of Mental Health did not provide ULS with any

investigation of his death, either by the Hospital or the Department, despite another tragic example of serious neglect by the nursing staff, resulting in a patient's death.

Mr. F, Died December 6, 2007

Mr. F died on December 6, 2007, at the age of 69. Beginning in 1980, Mr. F had been admitted to St. Elizabeths multiple times, and his most recent admission began on March 1, 2007. Mr. F's medical records contain an April 19, 2006, psychopharmacology and psychiatric consultation that describes him as a "chronically undersocialized, institutionalized, developmentally disabled individual, who now appears to be declining with a dementing variant of Parkinson's disease." Sadly, Mr. F's disease continued to progress and, in 2007, he experienced multiple medical problems that required repeated hospitalizations in the community. While ULS did not receive records that identified his cause of death, ULS' review of Mr. F's medical records found glaring and dangerous mistakes in the Hospital's provision of care to Mr. F.

Mr. F had a history of assaultive behavior, and he was often violent. The records reveal that the staff at St. Elizabeths failed to follow clinical recommendations regarding the treatment of Mr. F's dangerous behaviors, thereby placing him, other patients and the staff at a significant risk of injury. The Hospital staff also continued to prescribe antipsychotic medications that consulting physicians had recommended be discontinued, due to his extreme sensitivity to them and/or their ineffectiveness, placing Mr. F at an increased risk of severe medical complications that he had previously experienced when these drugs were prescribed. Also, as was the case with the other patient deaths in 2007, the records show that the St. Elizabeths staff did not consistently assess and monitor Mr. F when his condition deteriorated.

A Clinical Consultation and Support Team ("CCST") report dated July 26, 2007, states that Mr. F had "an exquisite sensitivity" to antipsychotic medications and a history of severe reactions to them, including severe Parkinson's disease and NMS. The report also states that multiple trials of antipsychotic medications, including Seroquel, Zyprexa, Geodon, Risperdal, Thorazine, Haloperidol and Prolixin, were not effective because Mr. F either had no response to the medications or had a severe reaction to them. His records contain several consultation reports that suggested that his assaultive behavior may not have been the result of psychosis, which would be treated with antipsychotics, but was likely caused by cognitive dysfunction.⁴² The April 2006 psychopharmacology and psychiatric consultation states, "It is far from clear that any of the [antipsychotic] medications have significantly improved [Mr. F's] impulsive behavior," and it was "impossible to discern" if any one medication had been effective due to the multiple medications that he was prescribed. Despite this considerable doubt that antipsychotic medications were effective, and the known risks of administering the medications to Mr. F, Hospital staff prescribed daily antipsychotic medications on his admission to St. Elizabeths, and they continued to be intermittently prescribed on a daily basis and/or "as needed" basis throughout his stay until his death.⁴³

Specifically, a neurology report dated May 9, 2007, suggests that Zyprexa, an antipsychotic medication, was “likely exacerbating” the symptoms of Mr. F’s Parkinson’s disease. Two months later, the above-mentioned CCST report states that the use of antipsychotics, including Zyprexa, was making “the clinical picture much worse” and that their use should be avoided, yet the records indicate that the Hospital continued to prescribe Zyprexa intermittently. Mr. F exhibited symptoms similar to an adverse medication reaction and required hospitalization on at least three separate occasions, within days after the Zyprexa was prescribed, including the hospitalization during which he ultimately died.⁴⁴

In addition to the problems with psychotropic medication administration, Hospital staff did not implement recommended behavioral treatments and techniques. A neurology consultation report dated June 5, 2007, states that “non-pharmacological management is an extremely important part of the treatment plan for [Mr. F]” and recommended that: male one-to-one staff be considered (since Mr. F rarely exhibited assaultive behavior with male staff); staff keep a reasonable distance from him; and staff avoid unnecessary interactions that had predictably upset Mr. F in the past. Recommendations from the July 2007 CCST report discussed ways of approaching Mr. F to minimize the risk of aggressive behavior, and suggested that a video be made for the staff demonstrating specific techniques. The records contain no evidence, however, that staff implemented these suggestions or developed a comprehensive behavior plan for Mr. F, which, if correctly implemented, could have decreased his assaultive behaviors. In fact, the CCST report states that the recommendation regarding male staff was not implemented “due to staffing problems.”

As was the case with several other patients who died in 2007, a staff person was required to be within arm’s length of Mr. F at all times due to his unpredictable behavior. The records indicate, however, that this did not always happen. Not only did the staff fail to develop and implement a behavior plan, but, in many instances, they also failed to adequately monitor Mr. F to protect other patients and staff. For example, on April 9, 2007, he hit a female patient in the face several times, and on June 1, 2007, he attacked a female staff person twice while she was behind the nurses’ station. On July 12, 2007, Mr. F ran down the hall and “stomped” on a female patient’s face with his foot, causing a severe laceration. Three days later, on July 15, 2007, he broke a lock and a window in his room.

In addition to his complex behavioral and neurological problems, Mr. F also had multiple medical diagnoses, including high blood pressure, hypothyroidism, renal insufficiency, hypercholesteremia, Parkinsonian dementia and a history of head trauma. In 2007, he was hospitalized multiple times with dehydration, failure to thrive, a change in mental status, and a fecal impaction with a partial bowel obstruction. As in the other patients’ deaths, similar patterns of nursing and medical failures emerged from ULS’ review of Mr. F’s records.

The records reveal multiple instances when, prior to being hospitalized, the nurses at the Hospital did not adequately assess and monitor Mr. F, despite symptoms of serious

clinical decline. For example, on April 25, 2007, Mr. F was admitted to Greater Southeast Community Hospital with decrease in appetite, Parkinsonism, hypertension and renal insufficiency. Two days earlier, on April 23, 2007, Mr. F was noted to be “rigid” and “nonresponsive.” The doctors’ notes indicate that Mr. F continued experiencing symptoms such as “unstable” vital signs, a marked increase in rigidity in his upper extremities, and concern that Mr. F was experiencing NMS. However, the nurses’ progress notes contain minimal mention of his clinical deterioration, no adequate assessments and no notation of his vital signs. Instead, with the exception of two RN notes stating that Mr. F was experiencing rigidity and excessive drooling (without further assessment and monitoring), the nurses’ notes seem to blame Mr. F for his condition, stating that he was refusing to get out of bed, was “in one of his mood swings,” and was uncooperative with treatment. The vital sign sheet indicates that the nursing staff only took Mr. F’s vital signs once each day between April 22, 2007, and April 24, 2007, despite a change in clinical condition and an elevated pulse.

Similarly, when Mr. F was admitted to a community hospital on July 20, 2007, with a diagnosis of dehydration and failure to thrive, the records demonstrate inconsistent monitoring of his fluid and food intake or his weight⁴⁵ prior to his hospitalization, even though his condition had deteriorated to the point that he required the insertion of a permanent feeding tube. On July 19, 2007, the day before he was hospitalized, the nursing notes indicate that Mr. F was not taking food and was drinking very little, and had a low pulse. On July 20, 2007, the RN’s note indicated that Mr. F had tremors in his hand. However, the records do not contain an adequate nursing assessment nor do they demonstrate that the nurses closely monitored his condition.

Mr. F was again hospitalized on August 13, 2007, and treated for urosepsis, dehydration and a high potassium level. Although the St. Elizabeths doctor noted that Mr. F had generalized rigidity, a confused state and was non-verbal, the records contain no nursing notes that assess Mr. F for these symptoms.

Despite his multiple medical conditions, the most recent annual nursing assessment in Mr. F’s records is dated October 2, 2007. The assessment is very brief and does not reference and/or detail many of Mr. F’s medical conditions. The attached nursing care plan is also very brief and fails to address many of his clinical conditions, including his diagnoses of Parkinsonism, hypertension and high cholesterol.⁴⁶ ULS’ record review also revealed examples of nurses apparently fabricating the administration of ordered medications. For example, the records indicate that Mr. F was admitted to Greater Southeast Community Hospital from April 24, 2007, to May 2, 2007, yet initials on the St. Elizabeths medication administration record (“MAR”) indicate that his multiple routine medications, vitamins and nutritional supplement were given to him during this time period. Similarly, although he was admitted to Greater Southeast Community Hospital from August 13, 2007, to August 30, 2007, the MAR contains initials to indicate that one medication and tube feedings were administered during this same time.

The records also contain evidence of the medical staff’s poor documentation of Mr. F’s condition. At times, GMO notes were brief, and they did not always indicate that

the doctor physically examined Mr. F. Monthly GMO notes, which were meant to summarize Mr. F's medical care and treatment, were not consistently written, and GMO notes frequently only addressed acute changes in Mr. F's clinical condition.

Finally, the records contain multiple recommendations for Mr. F to receive a physical therapy evaluation and treatment. For example, a psychology assessment dated June 28, 2007, recommends that Mr. F receive physical therapy for wider range of motion, to aid in developing additional muscles, and to decrease the risk of him falling and hurting himself. The transfer summary from Greater Southeast Community Hospital ("GSCH"), dated August 8, 2007, states that during his July 20, 2007, admission, Mr. F was evaluated by the GSCH physical therapist and that the therapist was working with him to implement bedside therapy, with a goal of walking. It further states that physical therapy should continue when Mr. F returned to the St. Elizabeths. Although multiple doctors' orders were written for Mr. F to receive physical therapy, there is no indication that he was ever evaluated by a licensed physical therapist at the Hospital. A note from a physical therapy assistant dated July 10, 2007, states only that "Mr. F is not a candidate for physical therapy at this time," without further explanation. The records contain two additional notes written by a physical therapy assistant in September 2007 stating that Mr. F was not evaluated because he "could not cooperate" or that he refused treatment. While a nurse noted on September 10, 2007, that Mr. F had made "marked improvement" and was "requesting to walk," a brief physical therapy assistant note, dated September 13, 2007, stated that Mr. F refused treatment.

Regardless of Mr. F's official cause of death, it is beyond question that the Hospital's treatment of his behavioral and neurological problems placed him at great risk. The Hospital's repeated administration of antipsychotic medications despite numerous recommendations otherwise, its inadequate responses to and interventions for Mr. F's assaultive behaviors, and the nursing staff's failure to monitor and assess his medical diagnoses adequately all contributed to, if not exacerbated, his clinical deterioration during his final admission to St. Elizabeths.

Mr. G, Died September 29, 2007

Mr. G died on September 29, 2007, at the age of 59, after suffering from chronic liver disease. He too did not receive adequate care at St. Elizabeths, even when his condition began to deteriorate significantly in August 2007. For two months, he battled symptoms such as extreme confusion, ascites (accumulation of fluid in the abdomen) and dehydration while he was shuffled back and forth to community hospitals six times. In addition to chronic liver disease, Mr. G had also been diagnosed with hypothyroidism, diabetes, hypertension, peptic ulcer disease, eczema and psoriasis. Despite presenting as a patient with multiple medical problems, Mr. G's medical records reveal numerous examples of deficiencies in care. For example, on September 3, 2007, the records suggest that he experienced a fourteen-hour delay in transport to a community hospital when his condition had deteriorated and the doctor's note stated that he should be transported to the emergency room "ASAP."⁴⁷ On September 14, 2007, the records contain no indication that the GMO at St. Elizabeths physically examined Mr. G upon his

return to the Hospital. The medical records also reveal instances of poor communication between the doctors at the community hospitals and the doctors at St. Elizabeths Hospital, despite numerous transfers.

As with other patients who died, Mr. G's medical records reveal many instances when the nurses did not perform adequate physical assessments, even when noting a change in clinical condition that would necessitate such an assessment. For example, an RN progress note dated July 21, 2007, states that Mr. G's "[a]bdominal girth is increasing (no tape to measure same)." Nothing in the records suggest that staff ever obtained a tape measure to adequately monitor and assess Mr. G's abdominal girth, nor was there evidence of daily weights, which would both be needed to adequately monitor a patient with ascites.⁴⁸ RN progress notes dated August 14, 2007, note that: Mr. G was "too weak" to come out of his room, he was disoriented and confused, and he was sent to the emergency room. Yet the notes do not include a nurse's physical assessment. Doctors' notes dated August 26, 2007, and August 27, 2007, state that Mr. G was in liver failure and "critically ill," experiencing nose bleeds due to the inability of his blood to properly clot, and having increasing blood ammonia levels. The records contain no nursing assessments on August 26, 2007. On August 27, 2007, the doctor's note indicates that Mr. G had no urine output since the previous day. This very serious condition should be monitored and treated as soon as it is recognized, but again there are no nursing notes referencing the lack of urine output or any indication that the nurses performed adequate physical assessments despite Mr. G's failing condition. In fact, the records contain no RN notes for the forty-eight hours before his transfer to a community hospital.

Tellingly, the annual RN assessment dated September 14, 2007, was inaccurate (the "no" box is checked for multiple medical conditions that Mr. G had) and did not include an assessment of any of his multiple medical diagnoses, despite his severely declining physical condition. The nursing care plan attached to the assessment is very brief, does not contain a plan of care for most of his multiple medical diagnoses, and does not address his significant clinical decline.

The medical records indicate that Mr. G's prognosis was poor. A nurse's note dated May 9, 2007, states that Mr. G realized how ill he was and that he was talking about issues related to dying. The records contain no notes, however, indicating that this issue was pursued and that Mr. G had a reasonable opportunity to discuss his thoughts and fears about having an incurable illness. A nurse's note dated June 9, 2007, states that he was "very sad," and there were multiple notes indicating that he refused treatment or to come out of his room during the last two months of his life. It was not until the day he died that a social worker from St. Elizabeths documented that Mr. G was a candidate for hospice care, although nursing home care had been mentioned previously. Nothing in the records indicates that end-of-life planning, which might have allowed Mr. G to die in a dignified, humane manner, occurred in any meaningful way.

Like many of the other patients who died in 2007, Mr. G was prescribed multiple psychotropic medications, yet there is no evidence that the Hospital staff monitored for

potentially dangerous side effects. And also like many of the other patients who died in 2007, ULS received no investigation related to his death.

Ms. H, Died on July 17, 2007

On July 17, 2007, Ms. H died at the age of 63, having been transferred from St. Elizabeths to the Intensive Care Unit at Washington Hospital Center more than a month earlier. According to a St. Elizabeths GMO, Ms. H died of “natural causes” and did not require an investigation by the Office of the Chief Medical Examiner.⁴⁹ ULS’ review of Ms. H’s medical records, however, indicates that in the months prior to her death, Ms. H experienced a number of acute changes in her clinical condition. Once again, the records provide no indication that the nurses adequately assessed and monitored her condition. In fact, the Hospital’s own death investigation report found “serious quality of care and practice issues, which require immediate supervisory corrective action, review and determination.”

Ms. H had a number of medical diagnoses, including Crohn’s disease, chronic diarrhea, lung disease, congestive heart failure, leukocytosis, hypotension and anemia. Despite her medical conditions, the records indicate that the nurses at the Hospital failed to adequately assess and monitor them. Nursing notes are infrequent; there are times when the medical records do not contain any RN progress notes for many consecutive days. Also, many of the nursing notes do not contain adequate physical assessments. There are significant gaps in the medical recording of vital signs, and multiple instances when the recorded vital signs do not include a temperature or respiratory rate. In addition, the records provided to ULS for review contain no annual nursing assessments or nursing care plans.

As early as August 9, 2006, Ms. H’s treatment plan states that she was experiencing “significant medical difficulties,” including low blood pressure, swelling to her feet and excessive diarrhea. Despite her many medical conditions, the most recent treatment plan was dated November 3, 2006, and did not contain the GMO’s signature to indicate participation in the plan’s development. The medical records indicate that in 2007, Ms. H continued to experience these and other symptoms of a decline in clinical condition, but in most instances, there are inadequate, or a total absence of, nursing assessments. For example, on May 24, 2007, an RN note indicates that Ms. H had swelling to her legs and “loose, foul smelling stools,” yet staff did not document an adequate nursing assessment.⁵⁰ On May 30, 2007, a nurse noted that Ms. H was “weak” and “frail,” her blood pressure was low at 88/60,⁵¹ and her pulse was elevated at 120 beats per minute. Despite these concerning symptoms and vital signs, the records contain no indication that the nurse completed an assessment, monitored her condition or recorded follow-up vital signs.⁵² In fact, there is not a single RN progress note after this entry until the day Ms. H was admitted to the community hospital on June 12, 2007, almost two weeks later, and the records contain no vital signs from June 9, 2007, to June 11, 2007. Ms. H died during this hospital admission.

Equally as troubling, in many instances the flow sheet for recording vital signs indicates that Ms. H had a low blood pressure and/or elevated pulse rate, which could indicate a number of serious, potentially life-threatening clinical conditions that would necessitate a nursing assessment, doctor notification and close monitoring of follow-up vital signs.⁵³ In most cases, however, the records do not contain corresponding RN notes and an indication that a doctor was notified.

For example, on April 27, 2007, Ms. H's blood pressure was recorded as being very low at 70/50, yet there are no RN or GMO progress notes for that day. On May 1, 2007, her blood pressure was recorded on the flow sheet as 72/53 with a pulse of 104, and on May 2, 2007, her blood pressure was recorded as 77/54 with a pulse of 123. There are no progress notes in the records addressing these abnormal vital signs; in fact, from April 29, 2007, to May 3, 2007, there are no progress notes at all. On May 9, 2007, Ms. H's blood pressure on the flow sheet was recorded as 72/52 with a pulse of 133, on May 10, 2007, her blood pressure was recorded as 80/60 with a pulse of 80, and on May 11, 2007, her blood pressure was recorded as 75/50 with a pulse of 114. Yet for these three consecutive days, there is no indication that staff addressed these concerning vital sign readings. The medical records contain a complete gap in progress notes from May 5, 2007, to May 14, 2007.

Throughout the medical records, the GMO monthly notes are typically very brief and, at times, contain no evidence that the doctor physically examined Ms. H. For example, the monthly GMO notes for April and May 2007 state only that Ms. H has Crohns disease, has a colostomy and is clinically stable. The Hospital's own investigation report notes that for these two months the GMO notes "lack[] physical assessments and simply restate[] the diagnoses." Even though Ms. H had many episodes of low blood pressure readings, the doctor's order states that vital signs were to be taken only once a month. In addition, a nutrition consultation dated September 27, 2006, documents that Ms. H lost forty-four pounds over a nine month period in 2006. There is no evidence, however, that the staff noted the nutritionist's evaluation or implemented the nutritionist's recommendations.

Again, these inexplicable failures to provide adequate care are serious displays of the Hospital's negligent, substandard treatment of patients with medical conditions. No one can know how much Ms. H may have needlessly suffered as a result of this deficient care.

Mr. I, Died July 4, 2007

On July 4, 2007, Mr. I, a 53 year-old patient at the John Howard Pavilion since March 2007, died after battling a number of illnesses, including late-stage HIV disease and hepatitis C, chronic liver disease and congestive heart failure. According to the Hospital's Major Unusual Incident Follow-Up Report, the cause of death was listed as cardiopulmonary arrest, with secondary diagnoses of cardiomyopathy and cirrhosis of the liver due to hepatitis C. Although Mr. I had multiple medical diagnoses and a poor prognosis, ULS' review of his medical records revealed multiple deficiencies in the

Hospital's basic nursing and medical care. For example, while the records contain an initial nursing care plan, this plan was inadequate because it did not specifically address Mr. I's multiple medical needs. For example, the outcome for the listed problem of "self-care deficit [related to] multiple medical conditions" was simply "[patient] will be compliant [with] treatment regimen."

Similarly, the medical records are devoid of evidence that the nursing staff at the Hospital properly assessed Mr. I's physical condition routinely or when he experienced deteriorations in his clinical condition, as he did frequently. For example, at 9:00 p.m. on April 2, 2007, Mr. I complained of vomiting, yet the records contain no evidence of an assessment, nursing follow-up, GMO notification or vital signs. The following month, on May 1, 2007, a GMO noted that Mr. I had been sent to the emergency room for shortness of breath, rales on his lungs (abnormal lung sounds) and tachycardia (an elevated pulse rate), yet the records contain no nursing notes for that day.

Although the nursing staff noted numerous complaints and changes in Mr. I's condition, they contacted the GMO inconsistently; when they did notify the GMO, there are instances when the notes contain no evidence that the GMO evaluated the patient or conducted a physical assessment. For example, on May 25, 2007, at 12:15 a.m., Mr. I vomited and was placed on "sick call," but the medical records contain no evidence that a GMO evaluated him at all the next day. Conversely, there are instances when the GMO evaluated a change in Mr. I's condition, but the records do not contain corresponding nursing notes, thus there is no evidence that the nurses were even assessing him, let alone planning and implementing care and treatment. Between March 20, 2007, and June 16, 2007, the GMOs made at least six entries in the progress notes about particular changes in Mr. I's condition, but the nurses did not.

In fact, although multiple progress notes indicate that Mr. I frequently complained of and/or seemed to be experiencing acute changes in clinical condition, including shortness of breath, chest pain, vomiting and constipation, in most instances the medical records contain no evidence that the registered nurses adequately monitored his condition, performed a physical assessment or intervened appropriately.⁵⁴ The medical records indicate that from June 25, 2007, until his final hospitalization on June 27, 2007, Mr. I complained of chest pain and shortness of breath, and he showed signs of clinical deterioration, including unstable vital signs. As a result, the Hospital sent Mr. I to the emergency room two times during these two days. Incredibly, the records contain no evidence, however, that the nursing staff ever completed a physical assessment of his condition during this time. On June 26, 2007, the records indicate that it took at least one hour for an ambulance to come for Mr. I, even after the nursing staff found that his vital signs were critically unstable.

Despite a significant decline in Mr. I's health, there is no record of any end-of-life planning for Mr. I. The progress notes indicate that from the end of May 2007, a little more than a month before he died, Mr. I was frequently yelling out, complaining of shortness of breath, vomiting and "moaning;" a progress note dated June 6, 2007, reported that he was "often anxious about dying." Yet, the medical records do not

contain an adequate nursing assessment evaluating these symptoms, nor is there evidence that the nursing staff developed a comprehensive nursing or medical plan to address his symptoms and alleviate his suffering. Adding to his ordeal, the medical records indicate that the Hospital placed Mr. I in medical isolation, requiring him to remain in his room twenty-four hours a day for more than twenty-five days at one time, without providing any active treatment or other activities. Although the medical staff placed Mr. I in medical isolation both in March 2007 and in June 2007, they never adequately addressed the isolation and the implications of such extreme segregation in a nursing care plan.

Mr. I's medical records contain no evidence that Mr. I was receiving antiviral medication or other medication to treat his HIV disease. Although it appears that Mr. I's GMO suggested that a referral be made to the Phoenix Clinic for HIV treatment, there are no records in his file from this clinic and no indication that the clinic ever evaluated Mr. I. Inexplicably, the nursing care plan does not even mention Mr. I's HIV disease.

In spite of the serious failures in the nursing and medical care Mr. I received, the Hospital's Major Unusual Incident Follow-Up Report did not find problems with the care and treatment provided to Mr. I at St. Elizabeths. Regrettably, DMH did not conduct its own investigation into Mr. I's death, again demonstrating serious failures in oversight that demand systemic reform.

Mr. J, Died in June 2007

Mr. J was in his mid-50s when he died in June 2007 of end stage renal disease after suffering cardiopulmonary arrest at St. Elizabeths on June 1, 2007. In addition to psychiatric diagnoses, Mr. J suffered from a number of medical conditions, including hypertension, diabetes, arthritis, and end stage renal disease. Like many of the other patients who died in 2007, Mr. J's medical records contain no evidence of adequate routine nursing assessments or monitoring in spite of his multiple medical problems, intake of fourteen different medications, and dialysis three times a week. For example, the records contain no evidence that the nursing staff adequately assessed or monitored Mr. J's post-dialysis condition or implemented his prescribed daily fluid restriction to prevent fluid overload, even after repeated complaints of edema (swelling) and hospitalizations for fluid overload. Similarly, the records contain no evidence that the nursing staff assessed Mr. J's weight in the month before he died. Previously, he had lost twenty-four pounds during a three-week period and the nursing progress notes made no mention of this drastic and dangerous weight loss.

In addition, the nursing care plans were extremely brief and failed to include Mr. J's multiple medical diagnoses; the plans also failed to respond to changes in his clinical condition, such as hospitalizations, the inability to ambulate without assistance, and increasing shortness of breath. When nursing staff recorded Mr. J's vital signs on the vital signs sheet, the records frequently did not include temperature or respiratory rate, two of the four elements of routine vital signs.⁵⁵ Disturbingly, there is no evidence in Mr. J's medical records of routine monitoring and screening for potentially serious side effects of the multiple psychotropic medications he was prescribed.

Not only do the medical records reveal a nursing staff that failed to assess and monitor Mr. J's ongoing treatment, but they demonstrate that the staff did not monitor and treat acute changes in his clinical condition. For example, having been found "lethargic, unsteady on his feet, holding on to the wall to ambulate" on March 11, 2007, the records do not contain an RN assessment again until March 23, 2007 – eleven days later – when he then complained of respiratory distress. Although the General Medical GMO ordered the RN to perform an oxygen saturation rate, the nurse did not perform one because a monitor was not available. The registered nurses did not conduct a further nursing assessment until March 29, 2007, when Mr. J had trouble breathing and the staff called 911 to transport him to a community hospital.

Throughout Mr. J's medical records, notes from the GMO indicate a change in condition, without a corresponding nursing note, either describing the initial need for the GMO's attention, or detailing the follow-up care. Without the corresponding nursing notes, the records suggest that the nurses did not monitor and assess Mr. J's condition, nor did they implement changes to his care and treatment. A number of RN progress notes indicate that Mr. J was short of breath, a symptom of fluid on the lungs, yet there is no evidence that the RN performed an adequate nursing assessment in response. The most recent annual RN assessment in Mr. J's medical records, dated February 17, 2006, consists only of check marks in boxes, and does not include a physical assessment, even though a nursing assessment should include both a nursing history and a physical assessment. Notably, Mr. J was sent to a community hospital multiple times before he died, but the medical records rarely contain evidence that the nursing staff performed assessments upon each of his readmissions to St. Elizabeths. In fact, when Mr. J returned to St. Elizabeths for the last time, the medical records do not indicate that either a physician or an RN physically assessed him.

Despite the significant deficiencies in Mr. J's nursing care, ULS received no records showing that either the Hospital or DMH conducted an investigation into his death, missing both a critical opportunity to examine the death in the larger context of the Hospital's provision of medical care to patients with co-occurring medical conditions and an opportunity to require much-needed corrective action. This failure is inexcusable.

Mr. K, Died in October 2007

Mr. K was in his mid-sixties when he died. His exact date of death is not clear from his records because he went on authorized leave in early October 2007 and never returned to St. Elizabeths. In mid-October 2007, the coroner informed Mr. K's social worker at St. Elizabeths that Mr. K was deceased. Neither the Hospital nor DMH provided ULS with any further information explaining the cause of Mr. K's death.

Although Mr. K's medical records indicate that the cause of death is unknown at this time, ULS' review of the records reveals that, once again, the nurses at the Hospital were not performing basic nursing functions. Inexplicably, the most recent dated nursing assessment form in Mr. K's medical records is from 2003, and the records do not contain a nursing care plan, even though Mr. K had chronic obstructive pulmonary disease, a

positive tuberculosis test, anemia and degenerative joint disease. The progress notes indicate that Mr. K experienced frequent changes in his clinical condition, including shortness of breath, urinary infection, pneumonia, abnormal chest x-ray, loose stool, constipation, low blood pressure and dizziness. Despite these conditions, there is no evidence that the nurses performed adequate physical assessments or adequately monitored his condition.

For example, a GMO note in mid-April 2007 states that Mr. K complained of “being dizzy” and having diarrhea, and that he “fell on the floor.” Another GMO note in early June 2007 states that Mr. K reported that he had suffered with loose stools since April. In both instances, there are no corresponding nurses’ notes, no evidence of nursing assessments and no follow-up doctor’s notes. Two brief RN notes on the same day in August 2007 state that Mr. K appeared flushed, his gait was unsteady, his temperature was 101.3 degrees and he was complaining of not having a bowel movement for five days, yet there is no evidence that the nurses conducted a complete physical assessment to determine the nature and extent of his illness. That evening, he was admitted to the hospital for eight days and diagnosed with a urinary tract infection and right lower lobe pneumonia. When he returned from the community hospital, a GMO note indicates that Mr. K’s blood pressure was low at 85/59 but that Mr. K states “he feels fine;” the medical records do not contain a follow-up nursing or medical note about Mr. K’s blood pressure until the following day. Similarly, on a day in mid-September 2007, Mr. K’s blood pressure was recorded as 70/60 on the vital signs sheet at 7:00 a.m., but the medical records do not contain a corresponding nursing note about this low reading. The records indicate that no one took a repeat blood pressure reading until 9:00 p.m. that night – fourteen hours later.

Nursing documentation in Mr. K’s medical records is very sparse. For example, the progress notes contain only one RN progress note per month for the months of January, February and March 2007. Other months contain only two or three brief nursing progress notes, which do not address Mr. K’s medical issues. Monthly nursing progress notes contain almost no assessments regarding physical complaints or hospitalizations. For example, the monthly progress note written in August 2007 does not refer to his eight-day hospitalization for pneumonia and urinary tract infection earlier that same month.

As with many patients at St. Elizabeths, Mr. K was prescribed multiple psychotropic medications, yet there is no evidence that the nursing and medical staff monitored for potentially dangerous side effects. Even if the treatment Mr. K received at the Hospital was not directly related to his death, the neglectful treatment he received, and the pain he may have suffered because of it, is inexcusable and should result in corrective action. Although requested, ULS received no investigation report concerning Mr. K’s death either from the Hospital or from the Department of Mental Health.

CONCLUSION AND RECOMMENDATIONS

The medical records and the District's own investigations of the patients' deaths in 2007 reveal a number of distressing patterns: significant gaps in both nursing and physician leadership; deficiencies in the delivery of medical care; dysfunction in nurses' authority and decision-making; and nurses' failure to perform basic and fundamental nursing functions, such as assessments, care planning, and implementation of nursing plans. As the primary caretakers of St. Elizabeths patients, RNs have the responsibility to perform their professional duties adequately. Even when patients experience significant deteriorations in their medical conditions, the nursing staff frequently does not perform adequate assessments and follow-up, placing the patients at risk of further decline and worsening symptoms, some of which are not recognized or treated until it is too late.

Given the alarming trends these patient deaths represent, ULS urges the District to take a number of immediate steps to prevent more needless suffering, or worse, more deaths. First, both the Hospital and the Department of Mental Health should conduct death investigations of every death at the Hospital. For those 2007 deaths that were not investigated, St. Elizabeths and DMH should investigate them immediately, identify problems with the quality of care, and take any and all corrective action, including personnel action, where indicated. Second, given the Hospital's serious failures, the District should retain an independent expert to perform a thorough investigation of the current provision of medical services to all patients at St. Elizabeths. The results of such an investigation should be made public so that the Hospital and the District can be held accountable. Third, the Hospital must undertake to re-train all nursing staff on basic nursing practice. Fourth, the Hospital must develop the necessary protocols to monitor medication side effects, and re-train all nursing and medical staff on such monitoring. Fifth, the Hospital must hire sufficient nursing and medical staff to ensure that it can adequately monitor every patient's condition, and respond to clinical changes, whether medical or psychiatric in nature. Finally, the Hospital must ensure that the nursing and medical administration is capable of and actually provides the leadership necessary to make these and other critical changes necessary to ensure patient safety at St. Elizabeths Hospital.

REFERENCES

¹ Despite requesting current Hospital census information through Freedom of Information Act requests in August and November 2007, the District has provided ULS with very limited information. The one census report the District provided – for December 19, 2007 – indicated that the census was 425.

² This report focuses exclusively on patients who died in 2007 and does not address ULS' other concerns about patient care, which are described in more detail in court filings.

³ ULS would like to thank the family members for agreeing to the release of the information related to the decedents in this report, thereby ensuring that their deaths were not in vain, and further ensuring that this report will bring awareness to a population that is all too often ignored.

⁴ At ULS' request, the medical records department at St. Elizabeths Hospital provided ULS with the patients' records from 2006 and 2007, with the exception of Mr. A's medical records, which ULS did not request to review. ULS reviewed the entire records provided, with the exception of the progress notes, which were only reviewed from January 1, 2007, until the time of the patients' deaths. However, Mr. D's progress notes were reviewed from October 1, 2006, until the time of his death. Although ULS requested the 2006 and 2007 records, a few unique documents that pre-date 2006 were contained therein, such as annual nursing assessments, patient history and physical forms completed by a doctor, and consultations from specialists. Andrea Procaccino, a registered nurse who provides consultation to ULS, performed the record review.

⁵ The practice of registered nursing means the performance of acts requiring substantial, specialized knowledge, judgment, and skill based upon the principles of the biological, physical, behavioral, and social sciences in the following:

- (a) *The observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms of health, disease, and injury, including the performance of examinations and testing and their evaluation for the purpose of identifying the needs of the client and family;*
- (b) *The development of a comprehensive nursing plan that establishes nursing diagnoses, sets goals to meet identified health care needs, and prescribes and implements nursing interventions of a therapeutic, preventive, and restorative nature in response to an assessment of the client's requirements;*
- (c) *The performance of services, counseling, advocating, and education for the safety, comfort, personal hygiene, and the protection of clients, the prevention of disease and injury, and the promotion of health in individuals, families, and communities, which may include psychotherapeutic intervention, referral, and consultation;*
- (d) The administration of medications and the treatment as prescribed by a legally authorized health care professional licensed in the District of Columbia;
- (e) The administration of nursing services including:
 - (1) Delegating and assigning nursing interventions to implement the plan of care;
 - (2) Managing, supervising and evaluating the practice of nursing;
 - (3) Developing organization-wide client care programs, policies, and procedures that identify the process to be utilized by nursing personnel to assess, identify, evaluate, and meet the needs of clients or population served;
 - (4) Developing and implementing an organizational plan for providing nursing services;
 - (5) Implementing an ongoing program to assess, measure, evaluate, and improve the quality of nursing care being offered or provided; and
 - (6) *Providing an environment for the maintenance of safe and effective nursing care.*
- (f) *Evaluating responses and outcomes to interventions and the effectiveness of the plan of care;*
- (g) *Promoting a safe and therapeutic environment;*
- (h) The education and training of person(s) in the direct and indirect nursing care of the client;
- (i) Communicating and collaborating with other health care team members and professionals in the development of the plan of care, management of the client's health care, and the implementation of the total health care regimen;
- (j) Teaching the theory and practice of nursing;
- (k) Acquiring and applying critical new knowledge and technologies to the practice setting; and
- (l) The pursuit of the nurse research to advance and enhance the practice of nursing.

17 D.C.M.R. § 5414 (emphasis added).

⁶ The definition of “neglect” for purposes of federal law under the Protection and Advocacy of Individuals with Mental Illness (“PAIMI”) Act includes “the failure to provide adequate nutrition, clothing, or health care to a individual with mental illness, or the failure to provide a safe environment for a individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.” 42 U.S.C. § 10802(5).

⁷ Richard A. Hodin, UpToDate: Sigmoid Volvulus (2007), http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/17324.

⁸ *Id.*

⁹ Side effects of antipsychotic medications include: (1) tardive dyskinesia (“TD”) – the late onset of uncontrollable movements of the tongue, face, neck, trunk or limbs, associated with prolonged exposure to antipsychotic medications; (2) movement disorders; (3) weight gain; (4) diabetes; and (5) neuroleptic malignant syndrome (“NMS”) – a potentially fatal condition presenting with fever, rigidity, mental status changes and autonomic instability. Michael D. Jibson, UpToDate: Overview of Antipsychotic Medications (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=psychiat/13184&selectedTitle=1~86&source=search_result.

¹⁰ “Small bowel obstruction (“SBO”) occurs when the normal flow of intestinal contents is interrupted.” Obstruction leads to dilation of the stomach and small intestine before the blockage. As the small bowel dilates, its blood flow can be compromised, leading to necrosis, strangulation and sepsis – all life-threatening conditions. Robert Quickel & Richard A. Hodin, UpToDate: Clinical Manifestations and Diagnosis of Small Bowel Obstruction (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/22094. Treatment for SBO includes surgery and/or careful observation.

Robert Quickel & Richard A. Hodin, UpToDate: Treatment of Small Bowel Obstruction (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/23412.

¹¹ “The most common symptoms of small bowel obstruction are abdominal distention, vomiting, crampy abdominal pain, and inability to pass flatus.” Robert Quickel & Richard A. Hodin, UpToDate: Clinical Manifestations and Diagnosis of Small Bowel Obstruction (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/22094.

¹² A nursing assessment would be warranted for a patient complaining of abdominal pain. The assessment would include determining the duration and severity of the pain, palpation of the abdomen, listening to the abdomen with a stethoscope for bowel sounds and percussion of the abdomen. *Manual of Nursing Practice* 47, 72-3 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).

¹³ “Systemic signs, such as fever and tachycardia [elevated pulse rate], are associated with strangulating obstruction.” Robert Quickel & Richard A. Hodin, UpToDate: Clinical Manifestations and Diagnosis of Small Bowel Obstruction (2007), http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/22094.

¹⁴ A normal heart rate is 60 to 100 beats per minute. Morton F. Arnsdorf, UpToDate: Normal Sinus Rhythm and Sinus Arrhythmia (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=carrhyth/9344&selectedTitle=4~150&source=search_result.

¹⁵ In this report, the term “antipsychotic medication” is used throughout to refer to a class of medications given to treat psychotic symptoms. Antipsychotic medications are sometimes referred to as neuroleptics. “Historically, several terms have been used interchangeably “Neuroleptic” is used in reference to first-generation (“conventional”) antipsychotics with significant risk for parkinsonian side effects “Atypical antipsychotic” or “second-generation antipsychotic” are the preferred terms for the newer drugs with less propensity to cause these side effects.” Michael D. Jibson, UpToDate: Overview of antipsychotic medications (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=psychiat/13184&selectedTitle=2~150&source=search_result. Psychotropic medications are a class of medications that include sedatives/hypnotics, antipsychotics, and antidepressants. Tatyana Gurvich, UpToDate: Regulatory issues and psychotropic drugs in the US nursing home (2007),

http://www.utdol.com/utd/content/topic.do?topicKey=geri_med/6531&selectedTitle=1~65&source=search_result.

¹⁶ “Infrequently, constipation is the first manifestation of ... obstructive intestinal disease; more often, it occurs as a side effect of commonly used drugs.” Arnold Wald, UpToDate: Etiology and Evaluation of Chronic Constipation in Adults (2007), http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/7390&selectedTitle=3~150&source=search_result.

¹⁷The Abnormal Involuntary Movement Scale (“AIMS”) is a rating scale that was designed to measure involuntary movements that sometimes develop as a side-effect of antipsychotic medications. Susan Hobbs, “Abnormal Involuntary Movement Scale,” 2 *Gale Encyclopedia of Mental Disorders*, available at http://findarticles.com/p/articles/mi_gx5197/is_2003?pnun=2&opg=n19119190.

¹⁸ See note 9 above for definition of tardive dyskinesia.

¹⁹ Diabetes insipidus, which can result from lithium toxicity, is characterized by a decrease in urinary concentrating ability that results from resistance to the action of antidiuretic hormone (ADH). Daniel G. Bichet & Burton D. Rose, UpToDate: Causes of Nephrogenic Diabetes Insipidus (2007), http://www.utdol.com/utd/content/topic.do?topicKey=flldlytes/11094&selectedTitle=1~129&source=search_result.

²⁰ Findings [of lithium toxicity] that may be observed include neuromuscular excitability, irregular coarse tremors, fascicular twitching, rigid motor agitation, muscle weakness, ataxia [unsteady gait], sluggishness, delirium, nausea, vomiting, diarrhea, leukocytosis, sinus bradycardia, and hypotension. Severe lithium intoxication can lead to seizures, stupor, coma, and a 10 percent risk of permanent neurologic sequelae (such as dementia and ataxia).” Nuhad Ismail, UpToDate: Lithium Intoxication (2007), http://www.utdol.com/utd/content/topic.do?topicKey=ad_tox/7870&selectedTitle=1~55&source=search_result.

²¹ Obstructive uropathy is a complete or partial blockage in the urinary tract that manifests in the inability of patients to urinate. Symptoms include pain and abdominal distention. Burton Rose, UpToDate: Diagnosis of Urinary Tract Obstruction and Hydronephrosis (2007), http://www.utdol.com/utd/content/topic.do?topicKey=renldis/12219&selectedTitle=1~150&source=search_result.

²² A suprapubic catheter is a catheter inserted in to the bladder through the abdomen to drain urine. Thomas Fekete, UpToDate: Urinary Tract Infection Associated with Indwelling Bladder Catheters (2007), http://www.utdol.com/utd/content/topic.do?topicKey=uti_infe/2922&selectedTitle=1~12&source=search_result.

²³ The progress note indicates that he was seen by the doctor at 2:00 p.m. for a finger injury. There is no mention of groin pain or abnormal vital signs.

²⁴ Subsequent vital signs are recorded in the progress notes that indicate his temperature was normal on the evening of June 19, 2007, and the morning of June 20, 2007.

²⁵ Urosepsis is a urinary tract infection that spreads in the bloodstream. Robert B. Nadler, Stacy Loeb & Itay Vardi, *Healing Well: Contemporary Management of Urosepsis: Updated Critical Care Guidelines* (2005), <http://mediwire.healingwell.com/main/Default.aspx?P=Content&ArticleID=168376>.

²⁶ The records indicate that, at times, Mr. D would refuse dressing changes.

²⁷ Ulcers should be categorized in stages in order to properly assess, monitor and treat. Stage I is non blanching red skin, Stage II is skin breakdown as far as the dermis, Stage III is skin breakdown in to the subcutaneous tissue, Stage IV penetrates bone, muscle or joint. *Manual of Nursing Practice* 187 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).

²⁸ The records indicate that occasionally the doctors would change the dressings of the decubitus ulcers and would sometimes note the size and degree of infection.

²⁹ Letter from Mr. D’s family, to Dr. Allen Gore, Associate Director of Medical Affairs, Saint Elizabeths Hospital (June 16, 2006) (on file with author).

³⁰ *Id.*

³¹ “Neuroleptic malignant syndrome (NMS) is a life threatening neurologic emergency associated with the use of neuroleptic agents and characterized by a distinctive clinical syndrome of mental status change, rigidity, fever, and dysautonomia.” Eelco FM Wijdicks, UpToDate: Neuroleptic Malignant Syndrome (2007), http://www.utdol.com/utd/content/topic.do?topicKey=medneuro/5946&selectedTitle=1~109&source=search_result.

³² “Patients restarted on neuroleptic agents may or may not have a recurrent neuroleptic malignant syndrome (NMS) episode.... If neuroleptic medication is required, the following guidelines may minimize risk of NMS recurrence. Wait at least two weeks before resuming therapy, longer if any clinical residual exist. Use lower rather than higher potency agents. Start with low doses and titrate upward slowly. Avoid concomitant lithium. *Avoid dehydration. Carefully monitor for symptoms of NMS.*” (Emphasis added). *Id.*

³³ *Id.*

³⁴ The medication administration record (“MAR”) indicates that the Valproate (also called Depakote) was restarted on May 24, 2007. ULS was not provided with the doctor’s order to restart the medication.

³⁵ Although the neurologist noted that Mr. E’s motor function had significantly improved after the discontinuation of the Valproate, he continued to fall.

³⁶ On several occasions, ULS staff visited Mr. E and noted that a staff person was not near him, let alone within arm’s reach of him.

³⁷ The doctors’ orders state that the nursing staff is to notify the doctor if the blood pressure is below 90/60.

³⁸ Arnold Wald, UpToDate: Etiology and Evaluation of Chronic Constipation in Adults (2007), http://www.utdol.com/utd/content/topic.do?topicKey=gi_dis/7390&selectedTitle=3~150&source=search_result.

³⁹ An ileus occurs when the bowel’s (or gastrointestinal tract) motility is disrupted, but there is no actual blockage in the bowel as is the case with a bowel obstruction. Babak Litkouhi & Michael G. Muto, UpToDate: Postoperative Ileus (2007), http://www.utdol.com/utd/content/topic.do?topicKey=gyn_surg/20448&selectedTitle=1~150&source=search_result.

⁴⁰ Although the doctor ordered double portions for meals and a Boost drink, the records contain no evidence that staff adequately monitored Mr. E’s intake of the added food or his weight gain or loss as a result.

⁴¹ The transfer summary from GSCH states that his discharge diagnosis was pneumonia and “vomiting, probably due to pneumonia.” There is no indication he was evaluated for a possible bowel obstruction or an ileus, although the discharge summary states his abdomen was soft, non-tender and not distended. This is significant because these are symptoms of intestinal ileus, the diagnosis at his death.

⁴² For example, a neurology report dated May 9, 2007, notes that a previous neurological consultation stated that there is a strong possibility of Parkinsonism and that Mr. F’s assaultive behavior was due to “cognitive dysfunction due to multiple factors such as pre-existing mental subnormality, small vessel vascular disease affecting brain and Parkinson’s disease.”

⁴³ The records indicate that Zyprexa, an antipsychotic, was ordered on a daily basis from March 1, 2007, until April 24, 2007, when Mr. F was taken to the emergency room with dehydration and NMS. After Mr. F returned to St. Elizabeths from Greater Southeast Community Hospital on May 2, 2007, his psychiatrist prescribed Seroquel, another antipsychotic, which he prescribed daily until June 21, 2007. Zyprexa and Geodon, both antipsychotics, were ordered and given “as needed” in July and August 2007.

⁴⁴ The records indicate that Geodon was prescribed and administered on July 15, 2007. Zyprexa was prescribed to be administered “as needed” on July 20, 2007, although it was not documented as given. Mr. F was taken to the hospital on July 20, 2007, at 3:15 p.m., after the nursing staff noted that he had a marked increase in tremors and that he was having difficulty standing and walking. Zyprexa was also ordered on August 8, 2007, and again on August 11, 2007. The progress notes and medication administration records (“MARs”) indicate that Zyprexa was administered on August 11, 2007. Mr. F was hospitalized on August 13, 2007, after the doctor noted that he was non-verbal and had increased general rigidity, and sent him to be evaluated for altered mental status and a confused state. On November 14, 2007, Zyprexa, 5mg daily, was ordered. The records indicate that he received doses on November 14, 2007, and November 15, 2007. The order was discontinued on November 15, 2007. Mr. F was transported to a community hospital on November 17, 2007, when the doctor noted that Mr. F had a stiff upper body with his arms flailing about, was confused and disoriented, and appeared dehydrated. Mr. F died during this hospitalization. Strangely, an order was written to discontinue the Zyprexa again on November 19, 2007, but then it was reordered on November 20, 2007, to be given on a daily basis, although Mr. F was hospitalized at the time and never returned to St. Elizabeths.

⁴⁵ The vital sign flow sheet indicates that staff only weighed Mr. F twice during his last admission to St. Elizabeths. On July 10, 2007, he weighed 126 pounds, and on November 1, 2007, he weighed 120 pounds.

Mr. F's nursing assessment, completed on October 2, 2007, indicates that he was 121 pounds. The records indicate he was 5 feet 8 inches tall.

⁴⁶ Although his most recent treatment plan, dated September 6, 2007, does briefly address some of his medical conditions as they pertain to the nursing staff, the nursing care plan is a separate document used for assessing, planning and implementing nursing care and treatment. At the very least, it should include a complete and detailed problem list, expected outcomes and individualized interventions.

⁴⁷ The GMO's order to transfer Mr. G to the ER is dated September 3, 2007, and timed at 12:30 a.m. An RN note timed at 3:00 p.m. indicates that Mr. G was transported at 2:45 p.m. It is possible that the GMO mistakenly wrote "a.m." instead of "p.m.," but that still means that the Hospital delayed more than two hours in transferring Mr. G to the emergency room after the GMO ordered it "ASAP."

⁴⁸ Assessment of ascites of the liver (fluid accumulating in the abdomen) includes daily measuring of the abdominal girth and daily weights. *Manual of Nursing Practice* 701 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).

⁴⁹ ULS received a copy of the Hospital's Mortality Review Report for Ms. H's death.

⁵⁰ A nursing assessment for loose stool or diarrhea should include information such as the frequency of the diarrhea, whether there is blood in the stool, associated factors such as fever, nausea, vomiting, abdominal pain, abdominal distention, frequency of the stools, length of symptoms and associated symptoms. The nurse should also assess the degree of dehydration. *Manual of Nursing Practice* 622-23 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).

⁵¹ A normal blood pressure reading is 120/80. Burton D. Rose, UpToDate: Patient Information: High Blood Pressure Overview (2007), http://www.utdol.com/utd/content/topic.do?topicKey=kidn_dis/5399.

⁵² The progress notes do not contain follow-up vital signs, and the vital sign flow sheet indicates that a blood pressure reading was not recorded until the following day, on June 1, 2007. That reading was also low at 82/60.

⁵³ Examples of clinical conditions that would manifest with low blood pressure and/or elevated pulse rate include: heart failure, heart attack, severe infection, blood clot to the lung and anemia. National Heart Lung and Blood Institute, What Causes Hypotension?, http://www.nhlbi.nih.gov/health/dci/Diseases/hyp/hyp_causes.html (last visited Dec. 28, 2007).

⁵⁴ For example, when a patient presents with shortness of breath, a nursing assessment should include a notation of the duration and intensity of the abnormal breathing, the presence or absence of chest pain, and a record that the nurse listened to lung sounds with a stethoscope and palpated the chest. Vital signs, including a respiratory rate, would also be recorded. Follow-up documentation citing the progression or improvement of the symptoms would also be indicated. *Manual of Nursing Practice* 64-67 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).

⁵⁵ Routine vital signs include taking and recording temperature, pulse, respirations and blood pressure. *Manual of Nursing Practice* 53 (Lippincott, Williams & Wilkins ed., 8th ed., 2006).