DISABILITY RIGHTS DC
at University Legal Services

A Patient's Suffering and Death at St. Elizabeths Hospital

October 1, 2018

Disability Rights DC at University Legal Services

Since 1996, Disability Rights DC at University Legal Services (DRDC), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for people with disabilities in the District of Columbia. DRDC has the authority to investigate allegations of abuse and neglect of people with disabilities throughout the District in accordance with the congressional mandate under the P&A laws, 42 U.S.C. §§ 10801 *et seq.*; 42 U.S.C. §§ 15043; 29 U.S.C. §§ 794e *et seq.*; 42 U.S.C. § 300d-53. Pursuant to the P&A laws, DRDC also has access to facilities in the District providing psychiatric care and treatment and can monitor these facilities for compliance related to consumer rights and safety. 42 C.R.F. § 51.42. In addition, DRDC provides legal advocacy to protect the civil rights of District residents with disabilities.

DRDC staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education and group advocacy efforts. DRDC 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, inclusion and special education, and the improper use of seclusion, restraint and medication.

I. Introduction

On "Month"[1] 23, 2017, Helen Sullivan[2], a patient in her thirties at St. Elizabeths Hospital (SEH) complained to nursing staff that she was experiencing a severe headache, which she had been experiencing for the past three days.[3] Over the next three days, Ms. Sullivan repeatedly complained to the nursing staff that she continued to experience a severe headache, which she described as "hammering," and "unbearable," and which was often not relieved with pain medication.[4] At one point she was noted to be screaming in pain and asking staff to take her to the hospital.[5] In the morning hours of "Month" 26, 2017, Ms. Sullivan began to exhibit an acute change in mental status, was noted by the nurse to be "confused, disoriented and unable to respond to questions" and that she "was getting more and more confused," "unaware of her surroundings" and was "unable to make meaningful statements."[6] Despite these emergent symptoms,[7] the nurses failed to call 911. Inexplicably, Ms. Sullivan was not transported to the hospital until 2:45 in the afternoon, over three and a half hours after she presented with life threatening symptoms, and even then, staff chose to transport Ms. Sullivan to the emergency room in the hospital van. In the emergency room at United Medical Center, a CT scan showed that Ms. Sullivan had suffered an extensive intracranial bleed.[8] She was airlifted to Washington Hospital Center and underwent emergency brain surgery.[9] Ms. Sullivan survived in the ICU for two days, but tragically she died on "Month" 28, 2017. The D.C. Medical Examiner determined the cause of death to be a ruptured middle cerebral artery hemorrhagic stroke due to hypertension.[10]

The record reflects that the nursing staff did not adequately respond to Ms. Sullivan's symptoms as required by basic nursing principles and responsibilities, and as required by the SEH Nursing Procedure Manual, ("the Manual.") Specifically, the nurses (1) failed to conduct adequate assessments; (2) failed to adequately monitor Ms. Sullivan's condition; (3) failed to ensure she was adequately evaluated by medical personnel; and (4) failed to call for emergency medical services when Ms. Sullivan was exhibiting urgent and emergent, life threatening

[1] The month the incident occurred has been replaced with the word "Month" to protect the privacy of the individual.
[2] Name changed to protect patient's privacy.
[3] SEH Nursing Progress note dated Month/23/17, timed at 11:07 p.m.
[4] A sudden severe headache is a potential emergency situation and is consistent with the symptoms of an intracranial bleed. See https://npwomenshealthcare.com/assessment-management-vol3-no3/ https://nurseslabs.com/intracranial-aneurysm/
[5] SEH Nursing Progress note dated Month/25/17, timed at 5:49 p.m.
[6] SEH Nursing Progress note dated Month/26/17, timed at 4:04 p.m.
[7] Hemorrhage and bleeding in the brain is a medical emergency which can occur as the result of head trauma, a serious bleeding disorder and **a bleeding cerebral aneurysm**. The signs and symptoms of this medical emergency can include **a severe, crushing headache** which is often referred to as a thunder clap headache, a sensation of popping in the head, a **decreased level of consciousness**, nausea, vomiting, **photophobia**, a postcoital headache, **confusion**, irritability, numbness, a stiff neck and/or back, visual changes such as the development of blind spots, double vision and/or the loss of vision in one eye, seizures, muscular pain, unequal pupils, and drooped eyelids. https://www.registerednursing.org/nclex/medical-emergencies/
[8] SEH GMO Progress note dated Month/26/17, timed at 5:42 p.m.
[9] SEH Nursing Progress note dated Month/27/17, timed at 6:06 a.m.
[10] D.C. Chief Medical Examiner Autopsy Report for Helen Sullivan dated "Month" 30, 2017.

symptoms. Ms. Sullivan could have received timely medical care for her condition. If properly evaluated and treated, her death may have been prevented.[11]

II. The Nurses Failed to Adequately Assess and Monitor Ms. Sullivan's Change in Physical Status as Required by the SEH Nursing Procedure Manual

SEH Nursing Procedure Manual requires the nurses to conduct "timely assessments by an RN throughout the individual's hospitalization … to identify changes in physical/medical status . . .."[12] The Manual requires the nurses to conduct a nursing assessment, which should include vital signs and an assessment of all relevant systems, including a neurological system assessment when indicated.[13] If the individual is not transferred out to a medical facility, the nurses are to document a narrative progress note at least every shift for 72 hours following the initial change in physical status to reflect continued nursing observations and reassessments and the individual's response to the interventions.[14] However, Ms. Sullivan's records contain scant nursing progress notes and reflect insufficient nursing observation, assessment, and monitoring -- serious violations of the SEH Nursing Procedure Manual and nursing neglect.

"Month" 23, 2017

The first documentation regarding Ms. Sullivan's complaints of a headache was dated "Month" 23, 2017. The single nursing progress note from that day, timed at 11:07 p.m., indicates that Ms. Sullivan reported a "severe headache this evening," that she had been having a headache off and on for three days, and that she "described pain at the top of her head." The note indicates that a call was placed to the doctor for further assessment, and that the doctor ordered Motrin 600 mg., which the nurse administered.[15] The note also indicates that Ms. Sullivan stated that she was given Tylenol in the afternoon for the headache with no relief.[16] The record contains no evidence that the nurses completed a neurological systems assessment, an assessment that would be indicated and required by the Manual after Ms. Sullivan complained of a severe headache.[17]

A GMO progress note indicates that Dr. Thura evaluated Ms. Sullivan that evening and concluded that Ms. Sullivan was experiencing a "[probable] migraine headache or migraine

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[11] The DBH office of Accountability investigated Ms. Sullivan's death. The report appropriately concludes that SEH staff failed to provide a timely assessment and failed to follow SEH policy regarding emergent medical situations on "Month" 26, 2017, the day Ms. Sullivan was transferred to UMC. DBH Office of Accountability Investigation Report 6/15/18. DRDC agrees with this conclusion. *However, the report does not address the serious and substantial violations in nursing policies and procedures regarding assessment and monitoring.* The report recommends changes and updates to existing hospital polices; however, it does not include adequate recommendations to ensure that this type of neglect will not occur again.

[12] SEH Nursing Procedure Manual 3-99 (I).

[13] *Id.* at (V)(A)(2)(c). A basic neurological assessment is indicated when a patient presents with a severe headache and/or change in mental status. The assessment should include the patient's orientation, pupil reactivity, and motor function and strength. http://file.lacounty.gov/SDSInter/dhs/208147_nursing.pdf.

[14] *Id.* at (V)(A)(2)(j)(v).

[15] SEH Nursing Progress note dated Month/23/17, timed at 11:07 p.m. The nursing progress notes for the three days prior to "Month" 23, 2017 fail to document that Ms. Sullivan had been complaining of a headache.

[16] *Id.*

[17] SEH Nursing Procedure Manual 3-99 (V)(A)(2)(c).

variant," that she was positive for photophobia and that "she will lie in her bedroom with the lights closed."[18]

"Month" 24, 2017

An RN progress note timed at 6:20 a.m. indicates that Ms. Sullivan reported a severe headache the prior evening, she had been having headache off and on for three days, she was given Tylenol the prior afternoon for this same headache with no relief and described pain at the top of her head. The note indicates that Ms. Sullivan went to bed afterwards, slept all night and *woke up in the morning with a severe headache*.[19] The note states that Ms. Sullivan "will be placed on sick call for further evaluation by the NP," and that nursing "will continue to monitor her."[20] Again, the progress notes fails to provide evidence that the nurses conducted a neurological systems assessment which was clearly indicated.

The above note was the only RN progress note for "Month" 24, 2017; therefore, the records contain no evidence that the nurses monitored or conducted further assessments as required by basic nursing responsibilities and the Manual. *In fact, the next nursing progress note in the record was not entered until over thirty hours later.*[21] This is a significant nursing failure, demonstrating no evidence of an adequate follow up assessments or adequate monitoring of Ms. Sullivan's complaints of a "severe headache." The records contain no evidence the nurses ensured that she was evaluated by a doctor or the nurse practitioner even though the nurse indicated Ms. Sullivan was placed on "sick call." In fact, records indicate that after the initial evaluation on "Month" 23, 2017, Ms. Sullivan was not evaluated by a physician again until *three days later* on "Month" 26, 2017, the afternoon she was transported to UMC.[22]

"Month" 25, 2017

Despite Ms. Sullivan's alarming headache symptoms, the nurses again documented only one progress note on "Month" 25, 2017. The progress note is timed at 5:49 p.m. (over 30 hours after the last nursing progress note) and indicates that Ms. Sullivan "took Tylenol this morning for headache and later this afternoon approached staff requesting to get something stronger because Tylenol was not helping."[23] The note indicates that a call was placed to the nurse practitioner and that a new order for Motrin 600 mg. was given at 2:08 p.m., "at which time [Ms. Sullivan] began to scream and hold her head requesting to be sent to the hospital because she was 'in labor.'"[24]

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[18] SEH GMO Progress note dated Month/23/17, timed at 8:13 p.m. (The records do not contain evidence that Dr. Thura followed up with Ms. Sullivan or nursing staff to ascertain the status of her headache and other acute symptoms after his initial assessment.)
[19] SEH Nursing Progress note dated Month/24/17, timed at 6:20 a.m.
[20] *Id*.
[21] SEH Nursing Progress note dated Month/25/17, timed at 5:49 p.m.
[22] SEH Medical Doctor Progress note dated Month/26/17, timed at 3:37 p.m.
[23] SEH Nursing Progress note dated Month/25/17, timed at 5:49 p.m.
[24] *Id*. Records reflect that Ms. Sullivan had a persistent delusion that she was pregnant. See SEH Psychiatry Progress note dated Month/10/17, timed at 2:37 p.m. As noted previously, this report focuses on nursing deficiencies. However, it should also be noted that the referenced nursing progress notes reflect a lack of communication and/or failure of the SEH medical staff to adequately respond to patients placed on "sick call."

The Pain Management Flow Sheet timed at 2:08 p.m., indicates that Ms. Sullivan complained of a "hammering and unbearable" pain in her head, with a severity of 10 out of 10.[25] A forensic psych tech note timed at 2:37 p.m. notes that Ms. Sullivan came out of her room crying. She stated that she needed to go to the hospital because she was in labor. She then continued to cry. She complained she was pregnant and was also having pains in her head.[26] Again, with such extreme, acute symptoms, the nurses were obligated to conduct a thorough assessment, adequately monitor her alarming symptoms, and respond appropriately by ensuring she received a medical evaluation by a physician and/or calling 911. Nothing in the notes demonstrates that this happened.

"Month" 26, 2017

A nurse manager progress note written at 4:40 p.m. on "Month" 26th, indicates that at 7:52 a.m. that morning Ms. Sullivan was administered Tylenol for a headache. The note indicates that after breakfast, Ms. Sullivan appeared confused, disoriented and unable to respond to questions, that the on-call psychiatrist and nursing supervisor were notified during morning rounds, and that there were "no new orders."[27] The nurse manager also notes that subsequently, during unit rounds, Ms. Sullivan was "getting more and more confused, unaware of her surroundings and was unable to make meaningful statements."[28] The note indicates that after an assessment (it does not indicate at what time or by whom), the GMO and psychiatrist determined that Ms. Sullivan was to be transported to the UMC via the hospital van. The note indicates she was not transported to the emergency room until 2:45 p.m.[29]

III. The Nurses Failed to Respond to Ms. Sullivan Urgent and Emergent Medical Condition as Required by the Nursing Procedure Manual

The SEH Nursing Procedure Manual describes an urgent medical situation as "any condition or illness that could develop into an emergency situation if not evaluated and treated expeditiously (within 30 minutes) by the GMO or NP."[30] The Manual requires that the RN "clearly communicate the clinical situation" and that an assessment by the GMO or NP is needed within 30 minutes.[31]

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[25] SEH Pain Management Flow Record dated Month/25/17, timed at 2:08 p.m. The Pain Management Flow Records are not consistent with documentation and are suspect. Three Pain Management Flow Records note the exact same response -- that exactly one hour after the administration of Tylenol or Motrin, Ms. Sullivan indicates her pain is at a level of zero to one on a scale of one to ten, and they also note the same phrase of "Very Happy; No Hurt." Not only are these assessments contradicted by progress notes which indicate that Ms. Sullivan told staff that the Tylenol was not helping with the pain, it is unlikely that pain from an acute intracranial bleed would be consistently, completely relieved after receiving Tylenol or Motrin.

[25] As noted previously, this report focuses on nursing deficiencies. However, it should be noted that the referenced nursing progress notes reflect a lack of communication and/or failure of the SEH medical staff to adequately respond to patients placed on "sick call."

[26] SEH FPT Progress note dated Month/25/17, timed at 2:37 p.m.

[27] SEH Nursing Progress note dated Month/26/17, timed at 4:04 p.m.

[28] *Id.*

[29] *Id.*

[30] SEH Nursing Procedure Manual 3-99 (III).

[31] SEH Nursing Procedure Manual 3-99 (V)(A)(2)(g).

The Manual defines an emergency medical situation as "acute symptoms of such sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of the individual. These situations are life threatening and require immediate assessment and/or treatment."[32] The manual instructs the nurses to "direct and initiate necessary actions to preserve the individual's health and safety, as well as call '911' when an emergent medical situation presents."[33] The SEH nurses failed to follow the procedures for urgent or emergent situations in addressing Ms. Sullivan's care, neglecting her needs.

The nurses should have been aware that an acute, severe headache as described by Ms. Sullivan over a two-day period -- "severe,"[34] "hammering," and "unbearable," and so painful that Ms. Sullivan was screaming and asking to be taken to the emergency room[35] -- was an urgent and/or emergent medical situation. However, the nurses failed to ensure that Ms. Sullivan was seen by the doctor within the 30-minute time frame required by an "urgent" medical situation. Nor did they call 911 as required by an emergent medical situation. Moreover, on the morning of "Month" 26, 2017, when Ms. Sullivan presented with continued complaints of a headache, an acute change in mental status, was unable to respond to questions, and was getting more and more confused,[36] the nurses should have realized that these symptoms were consistent with a stroke or an intracranial bleed, which is an emergent medical situation and they should have called 911.[37] The nurses also failed to ensure that Ms. Sullivan was seen by the doctor within the 30 minute time frame required by an "urgent" medical situation. Instead, an RN progress note indicates that the nurse manager made a series of ineffective phone calls to the psychiatrist and the medical doctor,[38] neither of whom appear to have come to assess Ms. Sullivan until that afternoon.[39]

The DBH investigation report supports the above findings and concludes:

> There was evidence to support that the SEH staff failed to obtain medical services and transfer HS off-site for an emergency on "Month" 26, 2017, as described in

[32] SEH Nursing Procedure Manual 3-99 (III).
[33] SEH Nursing Procedure Manual 3-99 (V)(A)(2)(f).
[34] SEH Nursing Progress note dated Month/24/17, timed at 6:20 a.m.
[35] SEH FPT Progress note dated Month/25/17, timed at 2:37 p.m.
[36] SEH Nursing Progress note dated Month/26/17, timed at 4:04 p.m.
[37] *See* https://www.registerednursing.org/nclex/medical-emergencies/
[38] An RN note written on "Month" 26, 2017, at 7:19 p.m., after Ms. Sullivan had been transported to the emergency room, supplies a timeline of actions taken by the nurse. The note indicates that the nurse notified the "on call team," Dr. Ghabra and the nursing supervisor of Ms. Sullivan change in mental status on Month/26/17 at 9:30 a.m. The note indicates that at 11:00 a.m., the nurse called Dr. Ghabra to assess Ms. Sullivan and that he "recommended cold compress, applied to forehead." At 1:00 p.m., Dr. Ghabra and the GMO were called to assess Ms. Sullivan. The note indicates that after "assessment" (does not indicate when or by whom), the GMO and psychiatrist ordered that staff transport Ms. Sullivan to UMC via the hospital van.
[39] A GMO progress note, dated Month/26/17, timed at 3:37 p.m., states that Ms. Sullivan "was seen for a headache and given Tylenol." The note indicates that Ms. Sullivan had an elevated blood glucose and that "there is a possibility that she is now diabetic." The note indicates that Ms. Sullivan was to be evaluated in the emergency room. Inexplicitly, the GMO fails to describe the serious symptoms described in the nursing progress notes that Ms. Sullivan was exhibiting, including a severe persistent headache and her significant change in mental status on the morning of "Month" 26, 2017.

> SEH policy 107.00. Per interviews…the nursing staff observed a change in status when HS urinated on herself on the unit, when urgent calls were made for [the doctor] to come quickly with the transfer and reports of HS drooling and leaning to the side in the admission suite prior to the departure from SEH. Despite all of these observations, HS's transfer was still considered a Non-Emergency Medical transfer; as she was transported by the SEH van and not by 911.[40]

IV. Conclusion

The records reveal a striking lack of required nursing assessment and effective clinical skills. These failures resulted in delayed emergency medical treatment and neglect. The nurses and medical staff at SEH must be adequately trained and have the ability to respond appropriately and timely to urgent and emergent medical situations. This is not the first DRDC death investigation that reveals inadequate nursing assessment and neglect.[41] Hospital administration must ensure that these long-standing failures are corrected now, before preventable tragedy occurs.

V. Recommendations

1. The SEH Director of Nursing should conduct a thorough review of the incident and the nursing care provided on the days preceding Ms. Sullivan's death.

2. All nurses involved in Ms. Sullivan's care in the week preceding her transfer to UMC should receive mandatory, competency-based training regarding the requirements of the SEH Nursing Procedure Manual and physical assessments.

3. The SEH Director of Nursing should conduct audits of all incidents of patients considered to have urgent or emergent medical situations and/or who were transported to the hospital for medical evaluation of their condition for the past six months. The audits should determine whether the nurses conducted adequate assessments and whether they followed the requirements of the SEH Nursing Procedure Manual. The results of this audit should be shared with DRDC.

4. DRDC requests a meeting to discuss the findings in this report with the SEH Director of Nursing, and the nurse manager and all the nurses involved in Ms. Sullivan's care on the days preceding her death.

5. DBH and DOH should initiate a plan to address the nursing and medical neglect in this report and to ensure that the nurses and medical personnel at St. Elizabeths are adequately trained and have the requisite skills to address the hospital patients' medical needs.

[40] DBH Office of Accountability Investigation report dated June 15, 2018 at page 33.
[41] See DRDC report, *A Report on a Painful Death*, February 11, 2013; DRDC letter to DBH, *Death of St. Elizabeths' Consumer, MP,* April 10, 2017.