BEHIND CLOSED DOORS:

Continuing Systemic Failures at the

Arkansas State Hospital

SPECIAL REPORT: NOVEMBER 2011

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This publication is made possible by 100% funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. These contents are solely the responsibility of Disability Rights Center of Arkansas and do not necessarily represent the official views of the funding agency.

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An Overview: Arkansas State Hospital and the Public Mental Health System in Arkansas

For nine (9) years prior to the opening of the Arkansas Lunatic Asylum in 1883, there was a requirement in the Arkansas Constitution that the General Assembly "…provide by law for the support of institutions for the education of the deaf and dumb, and of the blind; and also for the treatment of the insane." (*See* Article 19, Section 19 of the Arkansas Constitution, ratified and adopted in October 1874.) The General Assembly enacted legislation in 1873 creating the Asylum, but political football over the exact location of the hospital took the forefront for the next ten (10) years, and the building officially opened on March 1, 1883.

Since that time, a publicly funded state hospital has existed in one form and in one location or another in Pulaski County and central Arkansas. In 1905, the name of the facility was changed to the Arkansas State Hospital for Nervous Diseases, and in 1933, the name changed again to the Arkansas State Hospital (ASH).

At its peak census in the 1950s, ASH had 5,086 patients housed in multiple locations in Arkansas.[i]

Responding to growing public pressure and seeking a manner in which to manage admissions to ASH and access to the publicly funded mental health system, Acts of the Arkansas General Assembly passed in 1987, 1989 and 1991 gave responsibilities to Arkansas' network of Community Mental Health Centers (CMHCs) to screen and serve as single-points-of-entry for individuals seeking admission to ASH, and entry into the public mental health system in Arkansas. For many years, ASH provided in-patient services in a complex of buildings located at 4313 West Markham.

It was in that location that Disability Rights Center (DRC) discovered and investigated multiple allegations of abuse in 2005. After publication of DRC's multiple count investigation report, *Dirty Laundry*, administrators at the DHS Division of Behavioral Health Services (DBHS) implemented many of DRC's recommendations, but the effects of the changes were short lived.

In 2007, ASH dedicated space on Unit 3 Lower to house adolescent males with co-occurring mental illness and developmental disabilities, and actively marketed the unit as a means to qualify children with developmental disabilities for eligibility for the Division of Developmental Disabilities Services (DDS) ACS waiver.

A "new" ASH was dedicated on May 30, 2008. The new building had units for admissions of acutely mentally ill adults and adolescents, although forensic unit patients and adolescents with co-occurring developmental disability and mental illness were still housed in the "old" ASH.

However, the new building did not resolve the old problems of failure to identify, report, investigate and remediate allegations of abuse, neglect and exploitation of patients. ASH cannot simply maintain the status quo – what it needs is a true catalyst for change.

What happened to "Zero Tolerance?"

Following DRC's publication of *Dirty Laundry* in the summer of 2005, ASH committed to and adopted a practice of "zero tolerance" of abuse of its patients, accepting the resignation of the hospital administrator and several other staff, and revising policies requiring the reporting and investigation of alleged abuse.

However, after having created a separate Risk Management section of DBHS in 2005 to investigate allegations of abuse, neglect and exploitation of ASH patients, the retiring Director of DBHS inexplicably transferred supervision of the section to the newly selected ASH Administrator in December 2006, just prior to her retirement, leaving the fox guarding the hen house - again.

There was no way to know it at the time, but a routine monitoring visit to ASH by a DRC advocate on March 11, 2011, would lead to one of the most far reaching systemic investigations of care and treatment at ASH that DRC had ever undertaken.

That day, the advocate entered ASH's Unit 3 Lower – a unit that opened in the fall of 2007, and was designed to provide programming and treatment for adolescent males with co-occurring mental illness and developmental disability.

DRC had concerns about the unit in the past, not the least of which was the physical environment. When ASH opened its new multi-million dollar hospital in 2008, it left the boys with dual diagnosis on the old sixteen (16) bed hospital unit. DRC advocates who monitored ASH felt the unit was cold, sterile and dungeon-like. One of the advocates and DRC's Senior Staff Attorney met with ASH's Medical Director in September 2010 to discuss concerns about the unit, and to advise him DRC was considering filing an administrative complaint with the United States Department of Justice if ASH did not improve conditions for the youth housed there for long term admissions.

So on the morning of March 11, 2011, it was not surprising to the DRC advocate to see that if anything, very little had changed. There was the same lack of purposeful activity, with staff hanging around the nurses' station, while children in a classroom on the unit dozed on their desks or colored on sheets of paper photocopied so many times the pictures were hard to see. In one "pod" on the unit sat a single boy, the arms of his jacket wrapped around him in a manner characteristic of a straitjacket. He sat on the floor, under a table, rocking quietly. Before the advocate and two staff members accompanying her entered the room, the boy was entirely alone. The advocate asked the reason for finding the boy in the room by himself. She was told by the staff that his behavior had caused him to be placed on Intensive Treatment Programming (ITP), where he was separated from the milieu for twenty-four (24) hour periods of time until such time

as he conformed his conduct to that expected of him. Staff identified the child to the DRC advocate by his middle name.

Immediate Jeopardy - "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR Section 489.3.)

She asked where his schoolwork or other "programming" materials were. The staff told her he had them. Clearly, that was not true. There were no school texts, workbooks, or worksheets to be seen in the room – no activities or materials to keep him engaged in any kind of meaningful activity.

After the advocate's email to the nurse in charge of ASH's adolescent units went unanswered, she sent formal notification to ASH administration on March 15 that she would enter ASH the following day to begin an investigation. ASH identified the parents of the child to DRC, and parental authorization was secured to investigate DRC's concerns about the boy.

On March 16, DRC's investigation began with record reviews – both clinical and educational. These were followed by reviews of video footage of the unit, and it was during the reviews of video that the enormity of abuse and neglect on Unit 3 Lower – not only of the boy in question, but of the other ten (10) boys on the unit – was uncovered. DRC discovered that the boy in question was already the subject of an internal ASH abuse investigation, for allegations of significant verbal and psychological abuse of the child by ASH unit staff during the previous month – abuse that had been witnessed, but was not reported by other unit staff, in violation of ASH's promise of zero tolerance of abuse. Video of the incidents had been reviewed by ASH Risk Management staff three weeks prior to DRC's involvement, and reported to ASH Administrator Charles Smith who, outside of placing two staff on administrative leave, had done nothing about the abuse on the unit.

DRC filed a succession of complaints with the Centers for Medicare and Medicaid Services (CMS), resulting in CMS issuing four (4) findings of Immediate Jeopardy against ASH - on April 12, May 9, May 16 and June 24 – the last in connection with several episodes of violence by adolescent patients on ASH unit D.

On May 19, DRC met with staff from ASH and DDS to learn that DDS was committing the services of a consultant contracted to DDS to assist with the timely and effective discharge of adolescent males on Unit 3 Lower to return to the community with appropriate DDS supports – a process that was completed in full by November 6, 2011.

On the afternoon of May 27, CMS advised ASH in writing that although its Immediate Jeopardies had been lifted, ASH lost its deemed status as a Medicare provider, and as a result, would have to undergo a rigorous re-certification survey by the Arkansas Department of Health - almost as if it were a brand new hospital, opening its doors for the first time.

On June 17, DHS Assistant Director Janie Huddleston requested and received the resignations of David Laffoon, Director of DBHS, and Charles Smith, ASH CEO.

On July 1, 2011, CMS issued a final notice to ASH that its participation in the Medicare program would terminate effective July 18, 2011.

The "Systems Improvement Agreement"

Faced with the loss of critical federal funding, and finally recognizing that it did not have the ability to correct serious violations of Medicare Conditions of Participation (CoPs), DBHS Acting Director Janie Huddleston hired an Interim ASH Administrator, Randall Fale, effective July 1, and began working out a Systems Improvement Agreement (SIA) with CMS. The SIA was executed by both parties on July 18, 2011, the day previously set by CMS for termination of Medicare funding for ASH.

The SIA called for ASH – among other things - to find and contract with a mutually acceptable independent consulting firm that could identify specific areas of non-compliance with Medicare CoPs and help the hospital remedy areas of non-compliance. In return, CMS would "authorize a Medicare certification survey to determine ASH's compliance with Medicare CoPs no sooner than 180 days and no later than 365 days" from the effective date of the SIA.

The consulting firm found acceptable by both parties was Compass Clinical Consulting (also known as Compass Group, Inc.), based in Cincinnati, OH. As required by the SIA, Compass produced a detailed report in late September 2011, outlining numerous areas of non-compliance, and issuing the following statements in its Summary of Findings:

> *ASH has not been adequately managed for many years – a result of unqualified executives and poor governance practices. These conditions led to cultural and programmatic deficiencies that resulted in a failure to comply with the CoPs or with good hospital management and clinical practice.*

The ink was hardly dry on the SIA before DBHS and ASH met with DRC on August 1 to assure DRC that the new Interim ASH Administrator was committed to change and the safety and welfare of ASH patients. When Compass issued its Assessment for Centers for Medicare and Medicaid Services Compliance, DBHS released a two page list of "Improvements and Changes at ASH" to the news media, many of which were requirements under the SIA.

"Improvements" were not what DRC saw.

> "Poor communication was also observed in the interactions with senior and mid-level managers. Individuals in these positions should be able to influence others to adopt new behaviors but instead demonstrate a sense of helplessness. A pervasive attitude exists about 'this is how things are…' with little willingness or courage to challenge the status quo even in the face of glaring evidence that change is needed." (Compass Assessment, at page 59)

Case #s 1 and 2: Wait here while I go get some help…

Case #1:

August 26, 2011 was the date of the annual ASH art exhibition of works created by patients at ASH. Patients from Unit C, which houses people acquitted of crimes on the basis of mental disease or defect under court orders, attended the event.

Four (4) of those patients were accompanied by staff off the unit to the hospital lobby, where the art was exhibited. In the small garden and foyer outside the lobby, the hospital band, composed of staff members and patients, was playing music.

At approximately 7:30 p.m., staff noticed that one of the Unit C patients was missing. A search for him began and about 8:09 p.m., a "Be On the Lookout" (BOLO) was issued by the ASH Public Safety Office to the Arkansas Crime Information Center (ACIC).

Review of the evidence found that the four (4) Unit C patients who left the unit about 6:15 p.m. were accompanied by a Behavioral Specialist who had not notified the unit charge nurse that these specific patients were leaving the unit. In turn, the charge nurse had not granted permission for those specific patients to leave or checked to see if there was a doctor's order in their charts permitting them to attend the art show.

Additionally, an ASH staff member playing in the band reported that the patient in question came outside and sat beside him, remarking, "I don't know if I'm supposed to be out here." The staff member asked the patient to keep his seat and went inside the hospital to find the patient's assigned staff. When he returned, the patient was gone.

ASH received a phone call from the Lonoke County Sheriff's Department at 5:19 p.m. on August 27, advising that the missing patient was in its custody. ASH Public Safety staff drove to Lonoke County to get the patient and returned with him at 6:40 p.m.

Further review of the evidence revealed that although ASH Policy 05.04.01 (Maltreatment) required an internal investigation of this incident, there was not one completed. The ASH Risk Management section started an investigation, but an email from the Risk Management Director showed that, in a meeting with the Director (DON) and Assistant Director of Nursing (ADON) on August 29, Risk Management had been asked "…to delay our involvement until at least the first of next week." Although the DON and ADON each denied making such a request to Risk Management during their investigation interviews with DRC, no one was able to provide any evidence of response to the email contradicting what the Risk Management Director said. During his DRC interview, the Interim ASH Administrator said he thought the disciplinary investigation conducted by the ADON **was** the internal investigation, and seemed to be

Useful Acronyms

ADON - Assistant Director of Nursing

ASH - Arkansas State Hospital

BHA - Behavioral Health Aide

CMS - Centers for Medicare and Medicaid Services

CoP - Condition of Participation

DBHS - Division of Behavioral Health Services

DCFS - Division of Children and Family Services

DDS - Division of Developmental Disabilities Services

DON - Director of Nursing

LPN – Licensed Practical Nurse

RN – Registered Nurse

PSO - Public Safety Office/Officer

SIA – System Improvement Agreement

USO - Unit Safety Officer

unfamiliar with the requirement in ASH Policy 05.04.01 (Maltreatment) for an investigation of possible neglect, as defined by the policy. Additionally, the Interim Administrator was not familiar about times when ASH patients required staff supervision, stating, "…I don't know under what terms they get to go out, and what requires supervision and what doesn't. I mean, I just don't know."

By September 2, the ADON had conducted disciplinary investigations of all nursing staff and subordinates involved in the elopement, and concluded that no one was at fault, even though ASH Nursing Policy NUR 50.30.10 was violated by several staff.[iii] An ASH patient under court order walked right out the front door of the hospital, and according to ASH, no one was responsible.

Case #2:

On September 19, 2011 a male patient from forensic unit 5 Upper was taken for a fresh air break to a forensic unit courtyard in the company of two ASH staff and other patients from the unit. Evidence reviewed indicated that the patient went to the end of a corridor and sat down in an area that was not well-lit. A Behavioral Health Aide (BHA) asked the patient to move to another area of the courtyard, and when he refused, she left to find the Unit Safety Officer (USO) to accompany her to tell the patient to move to the area she indicated.

When both staff returned to the darkened corridor, the patient was gone. A BOLO was issued by the ASH Public Safety Department through the ACIC. The unit charge nurse's incident report documented that she was unaware the courtyard in question had been closed by the Public Safety Office earlier that afternoon at 3 p.m. due to the fact that it was not a secure location in which to take patients.

The patient subsequently was located unharmed at a local hospital emergency room the next day, and returned to ASH at 4 p.m. on September 20, 2011. Although the elopement occurred on September 19, 2011, debriefing about the incident did not occur with unit staff until October 10, 2011, and that in turn delayed the internal analysis of the root cause for the elopement.

Both of these incidents had a common element. In both situations, ASH staff knew that there was a possibility of a patient leaving the hospital, and in both cases, instead of summoning help to come to them, they left the patient unattended to go get help, providing the patients with the opportunity they needed to leave.

The Interim Administrator did not see any commonality in the two incidents of patients at ASH under court order who went missing from the hospital for nearly a day each. When DRC attempted to compare the fact situation of both incidents, i.e., staff suspected that something was

not right about the situation and left the patient alone to go get help, only to return and find the patient gone, he stated, "I don't know that in either instance. I'm not familiar with that in either instance. I'm not aware of that."

Question: "The documents that I've been provided, you haven't…you haven't actually read them yourself."

Answer: "No, I have not."

Case #3: Stabbing of CJ

Just before 8:30 a.m. on September 26, 2011, patient CJ was sitting beside his 1:1 staff at a table in front and to the left of the nurses' station on Unit 5 Lower. Leaning against the wall behind CJ and to his right was another male patient, also with 1:1 staff. That patient was wearing a "hoodie" that almost completely obscured his facial features. He stood with both hands in his pockets.

As noted on video of the incident, the second male patient's 1:1 staff stepped forward to lean in and listen to a staff member approaching him. As the staff member stepped away, the second male patient lunged forward and with his right hand, stabbed CJ in the throat with a homemade shank fashioned from a spring broken from his mattress. Although it appeared on the video that he drew back to stab CJ a second time, unit staff instantly intervened and moved him away from CJ, into a pod area behind the table where CJ was sitting.

CJ was hospitalized in intensive care at UAMS for five (5) days, with a puncture wound to his trachea.

This incident was completely preventable.

At 1:05 a.m. in the morning of September 26, the patient who would stab CJ after breakfast was found by a Unit 5 Lower staff member with his bedsheet knotted around his neck and tied to his bedroom door, trying to move a laundry basket into place to stand on and commit suicide by hanging. The bedsheet was removed, the patient assessed and medicated, and a physician's order was given to place him on suicide precautions with 1:1 staff.

However, no search was conducted of his room to see if he had formed a back-up plan in the event that his first suicide attempt was unsuccessful. His room was not searched until after he stabbed CJ. When the search was conducted, PSO staff found more pieces of the bed spring hidden in his socks.

On October 5, 2011, DRC asked the ASH Medical Director why it was not routine to search the rooms of patients who had attempted suicide while in the hospital. He replied, "Good point," and made notes about the question. It was apparent from review of chart documents that the physician's written order at 1:15 a.m. to "[r]emove shoelaces, belts and any other potentially dangerous items from person and patient's room" was not carried out, or the other pieces of broken bedspring would have been found.

DRC asked about any policy requirements related to physical proximity of 1:1 staff to their assigned patient, and was told by the Medical Director that he thought it was arm's reach, but he wasn't sure it was in the policy, although he knew it was the current practice. DRC review of ASH Policy NUR 50.30.21 (Suicidal Observation) revealed that, with the exception of a 1:1 patient in the bathroom, there was no statement of required distance contained in the policy to be maintained by staff from the patient under observation.

DRC was also concerned that initial Risk Management notes on the incident revealed that historic information about the patient who stabbed CJ contained in his forensic evaluation was not available to unit staff because the evaluation was not in the chart. The evaluation noted that the patient was found with a shank while in jail, and could have served as an early warning to unit staff had it been available to them.

DRC also questioned why the patient was allowed to wear a hoodie that obscured his face. The Medical Director said that several ASH patients use their hoodies as self-calming techniques, and staff are aware that the practice is effective for those patients.

However, the patient who stabbed CJ was not as well known to staff – he was newly admitted to the hospital on September 22, and had refused to answer several questions on intake questionnaires.

According to legal counsel for ASH, no internal investigation was conducted of this incident. The incident qualified as a sentinel event for purposes of ASH's accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO). Counsel for ASH refused to release the root cause analysis and action plan ASH was required to submit to JCAHO on the sentinel event, redefining those documents as "peer reviews"[iv] not subject to P&A access authority.

Case #4: Handcuffing of CC

In the late evening of September 26, 2011, CC was unable to sleep. He gave the USO on Unit 6 Lower a note at approximately 11:30 p.m., asking for sleeping medication. The USO took the note to the nurses' station and showed it to an LPN, and told the RN what the note said. The RN told the USO to go back and stay with the patient.

As evidenced by video of the unit, CC continued to write notes, at times obtaining more paper from staff on the unit. In one of the notes, he made reference to handcuffs,[v] but the sentence containing the words "handcuff me" is very hard to read for context. The USO continued to monitor the patient, who used the restroom, and the LPN also came to the pod where the restroom and patient bedroom were located. In the meantime, the RN requested and received an order from the doctor on call to administer Ambien to the patient.

However, the USO was unaware of that order, and picked up a bag containing mechanical restraints. He began walking back to the pod where CC was. He was stopped by the LPN and a BHA, who reminded him restraints could not be used without a doctor's order.

The use of seclusion and restraint on persons with mental health and/or addictive disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per annum across the nation. Children have been noted at especially high risk for death and serious injury. Individuals with addictive or co-occurring mental health and addictive disorders also appear to be at risk due, in part, to the possibility of increased agitation.

Source: SAMHSA statement, revised and adopted 2003

http://www.samhsa.gov/seclusion/sr_handout.aspx

The events which transpired next were nothing short of incredible. The USO made a phone call to the Public Safety Office, told the PSO who answered the phone that there was an out of control patient on the unit, and handcuffs were needed. When the PSO arrived, CC was sitting on a couch in the pod. The PSO spoke to CC, and then handcuffed both of his hands to the left arm of the couch.

The PSO then went to the nurses' station to let staff know that at the request of the USO, he had just handcuffed CC to the couch. He was told by the RN to release the patient.

But he couldn't. He didn't have a key to his personal set of handcuffs, the ones he used to cuff CC to the couch. Now, CC was getting truly agitated. The PSO had to go back to the Public Safety Central Control Office to obtain a handcuff key. CC was handcuffed to the couch for twenty-two minutes. During that time, the RN phoned the doctor on call to obtain an order to handcuff CC.

Although he should have been aware that ASH policy prohibited handcuffing a patient to an object, the doctor issued the order. He came to the unit to sign his order, and even though he considered the handcuffing of CC to be a restraint, he violated ASH Policy 05.01.07 (Use of Seclusion and Restraints), indicating he had visually assessed CC afterward as required by the policy, when in fact, he had not.

ASH's October 6, 2011, internal investigation report substantiated maltreatment of CC by both the USO and PSO. The Administrative Review Committee disagreed with the finding as related to the USO, although it felt that he should be counseled. The Committee upheld the finding of maltreatment by the PSO. He was terminated from employment at ASH on October 11, 2011. The USO and RN were issued Non-Disciplinary Counseling Statements on November 3, 2011. The physician was given a Written Warning on October 17, 2011.

Case #5: Restraint and seclusion of JH

As part of its effort to assist ASH in becoming compliant with the Medicare CoPs, and avoid having CMS terminate ASH's federal funding, Compass asked the Risk Management section to retrospectively review one seclusion event each day from various units all over the hospital.

As a result of a review of the seclusion of JH, an adolescent male in DCFS custody, on October 18, 2011, Risk Management opened an internal investigation into an allegation of maltreatment and filed the required report with the Child Abuse Hotline. The internal investigation was ongoing when DRC requested information on JH due to an allegation it received about the patient being sent to Unit 3 Lower during his waking hours to protect him from other peers on adolescent Unit D, where violence has been frequent since May of this year.

JH liked going to Unit 3 Lower and participating in the program there. He liked it so much that he became quite upset and agitated on October 18 when he asked the Unit D USO if he could go. The USO asked the RN, and he said, "no." After hearing that, JH struck out at the USO, trying to hit her.

The RN did not recall that exchange with the USO, and when interviewed by DRC on November 7, didn't seem to recall much else about the incident either. Especially not the way in which the USO and contract agency BHA "escorted" JH to the seclusion room, holding him facedown by his arms, with his feet and legs dragging on the floor. He wasn't looking, he explained – he was ahead of them, going to unlock the seclusion room. When he opened the door, he stood behind it, and couldn't see through the plexiglass window that the USO and BHA just tossed JH inside. JH immediately rolled over to a sitting position, cried out, and clutched his knee.

DRC interviewed all three staff members involved in the seclusion incident. The USO did not customarily work Unit D - she was usually assigned to Unit E. She became quite emotional during her DRC interview, expressing her frustration at not being given clear direction by the RN, and not having what she felt were enough staff members to handle the incident without someone getting hurt.

The private agency BHA was working on Unit D for the first time, and felt overwhelmed at the number of patients he had to supervise, which he said was fourteen (14) on the evening of October 18.

The RN had worked at ASH for three months, and his clinical background and experience was in oncology. Although the RN acknowledged that under ASH policy, he was in charge of the unit, as well as the seclusion of JH, when shown a copy of ASH Policy 05.01.07 (Use of Seclusion and Restraints), he acted as if he was seeing it for the first time. All three staff agreed that none of them had complied with ASH Policy 05.01.07, nor had they incorporated the physical holds they learned in their training on Non-Abusive Physical and Psychological Intervention (NAPPI).

ASH Policy 05.01.07 was revised on September 29, 2011. One of the revisions related to the manner in which ASH staff are permitted to get a patient into a seclusion room.

> When seclusion is deemed necessary by the physician or registered nurse **the patient must be taken in a standing position to seclusion.**
> In the event this cannot be accomplished:
> (a) an extended physical hold may be necessary to assist the patient in calming; or
> (b) the physical restraint bed and restraints may be utilized to transport the patient to the seclusion room if needed. [vi]

The private agency BHA was emphatic that he had never seen the policy in that form, and further stated that he was just taking his direction from the USO because the RN had said nothing to him at all. The USO said she knew about the policy change, but was not getting any assistance or direction from the RN.

To further complicate matters, the nurse evaluator who came to conduct the required face-to-face assessment of JH while in seclusion said she had to tell the unit RN to open the door, because JH

was calm. She then wrote on her report, "Pt states that peer hit hit (sic) and hurt his knee when asked if he was physically okay." When DRC asked her in a November 4 interview why she wrote that on the report, because the video did not back up what she wrote, she replied that someone told her another peer hit JH when he struck the USO. She could not recall who gave her that information.

Systemic Issues

What Are They Hiding?

Current management staff at ASH seem to be determined to keep what happens behind the closed doors of the hospital to themselves. In 2011, while ASH was being closely monitored and investigated by CMS, DRC experienced barriers to its federally authorized access authority not encountered since it first began monitoring care and treatment at ASH in 1987.

Delays and denials of DRC's access became even more pronounced after the hiring of the Interim ASH Administrator in July. In a purported effort to centralize document production, the Interim Administrator decided that production of all document and information requests would be coordinated through the ASH Director of Medical Records, rather than through Risk Management, which previously had been DRC's point of contact for requests for documents, video and information for DRC investigations.

Only a portion of documents and information related to DRC investigations of allegations of abuse/neglect/rights violations are actually medical records. Incident reports are not considered by ASH to be medical records. The Incident Report form – ASH Form 05.01.06 F1 – clearly states, "DO NOT PUT IN CHART." As a matter of course, this is not a document which a Director of Medical Records would be expected to see and have access to, nor is video of an incident. Both, however, are records of use in investigations with which staff in Risk Management are very familiar. Likewise, documentation of disciplinary action taken against staff involved in substantiated allegations of maltreatment of patients (as described by ASH Policy 05.04.01) is not information contained within a medical record.

All of the above set the stage for delays and denials of access, due to the Director of Medical Records not being aware of all the types of documents used in an investigation, as well as failure of staff who are the actual custodians of information sought to reply to her attempts to get the information. During DRC's investigation of Case #4, documents requested on October 5 were not provided to DRC until November 4, and then only because the DRC advocate went to Nursing Administration and got them herself.

And it was not only DRC from whom ASH tried to shield information. None of the five (5) cases reported previously in this report were reported by ASH to CMS or to Compass, ASH's partner in the implementation of the SIA. DRC reported all of them, and ASH provided information about them to Compass and CMS when asked.

In addition, there appears to be little to no clinical oversight of ASH by the Medical Director of DBHS, who previously served as Medical Director for ASH. When DRC requested his review

of one of the cases discussed in this report, he was unaware that it had even occurred. It is perplexing that ASH and DBHS failed to identify this need, particularly in light of Compass' finding that, "The Medical Director and Director of Nursing are typical examples of promotion from within but with inadequate preparedness for their executive level positions."[vii]

Ironically, if ASH spent as much time and energy asking for assistance as it does trying to hide information, all of the entities noted in this section could be useful to the administration of ASH in its efforts to provide clinically competent mental health services to Arkansans with mental illness in a safe and therapeutic environment.

ASH Policies

As was the case in 2005, ASH has policies in effect designed to guide and direct staff in performance of their duties.

As was the case in 2005, knowledge of and compliance with ASH policies - all the way to the Administrator's office - is spotty and haphazard. In Case #5, the contract agency staff had not been given a copy of newly revised ASH Policy 05.01.07 (Use of Seclusion and Restraints), nor had he been trained on it. Nonetheless, he was sent to an adolescent unit where he had not previously worked where compliance with the policy was critical, and would be required on almost every shift. As a result, a patient was injured, and the policy was violated by all three staff involved in the seclusion.

As was the case in 2005, the real world effect of ASH's policies can only be as good as the dissemination, discussion, training and implementation of them.

The Hospital Administrator

The Interim ASH Administrator seems to be disengaged from the daily operations and activities of ASH. During his introductory meeting with DRC on August 1, 2011, he made it clear that DRC was to contact the Medical Director and DON with any issues found during monitoring and management of DRC cases on ASH patients. When asked for clarification, he said that direction was also to include matters of solely an administrative nature, e.g., policy questions, issues involving ASH's police department, etc.

He has continued to maintain that posture, notwithstanding the fact that Compass, as discussed earlier, enumerated concerns about the capability of both individuals to discharge their job duties as administrative staff. During the few meetings and contacts DRC had with the Interim Administrator, he made statements to the effect that he was still new; was unaware of requirements of the ASH policy on alleged patient maltreatment; wasn't familiar with the ASH employment discipline process; and did not know what level of supervision was required for patients court ordered to ASH. By way of explanation, he again said he "had people" who took care of all of those issues.

The same people criticized by Compass.

The Interim ASH Administrator began his contract with a two week vacation. About a month after Compass issued its Assessment, he took another two week vacation, leaving the DON in charge of the hospital as Acting Administrator in his absence.

Compass has placed enormous faith in the capabilities of the Interim Administrator, stating, "Similarly, senior executives of both past and present were unprepared for their roles, *with the exception of the current interim CEO*."[viii] In her November 2 interview with DRC, Janie Huddleston indicated she had similarly high expectations of him. He will have to become actively engaged to meet either's expectations.

Investigations of Alleged Maltreatment

Subsequent to the relocation of the Risk Management section back to ASH, the ASH Administrator added supervision of other ASH sections, i.e., Incident Management, Compliance, Performance Improvement and Environmental Safety, to the responsibilities of the Director of Risk Management, even as the one permanent full time investigator assigned to Risk Management spent most of 2011 away from ASH on approved medical leave.

The Risk Management section is currently operating with one part-time, extra help investigator. During the course of DRC investigations of the five (5) cases outlined in this report, the Incident Manager of the Risk Management section resigned. As the final version of this report was being completed, DRC received notice that the Director of Risk Management was no longer in that section, leading to more concern about ASH's capacity to fully and thoroughly investigation alleged abuse, neglect and rights violations of patients.

Additionally, the Administrative Review Committee, composed of five (5) ASH administrative staff, conducts reviews of Risk Management investigations in which allegations of maltreatment have been substantiated, per ASH Policy 05.04.01 (Maltreatment). Any three to two (3 to 2) votes of the members of the Committee must be forwarded to DBHS for review.

In a review of twenty-seven (27) internal investigations from June 1 through September 23, DRC found several instances of two members of the Administrative Review Committee – the Interim ASH Administrator and Director of Risk Management – abstaining from voting, thereby precluding the possibility of oversight by DBHS.

Recommendations

ASH should re-train all staff, including administrative staff, in all policies that were revised within the last twelve (12) months, and document such training in each staff's personnel file.

Internal investigations of alleged maltreatment of ASH patients should be removed from the ASH organizational structure and re-located to DBHS. Sufficient numbers of trained investigators must be recruited and hired.

ASH Policy 05.04.01 (Maltreatment) should be revoked in part, beginning with the section called *Procedure*, and a DBHS policy covering investigations of maltreatment at ASH should be developed in its place.

Until such time as the two previous recommendations are implemented, the DBHS Medical Director should be included in the notifications required under the "Procedure" section of ASH Policy 05.04.01.

The DBHS Medical Director should have direct oversight of clinical functions at ASH.

During the pendency of the SIA, ASH should report all incidents requiring investigation pursuant to ASH Policy 05.04.01 (Maltreatment) to CMS and Compass.

ASH should provide all new and contract agency staff with orientation to the units in which they are asked to work, and should not permit an entire shift on any unit to be comprised of newly hired and/or contract agency staff.

ASH should begin comprehensive incident analysis on each unit of the hospital in order to identify times of day and other antecedents to occurrence of reportable incidents on each unit in order to identify clinically appropriate methods to reduce the number of incidents and resulting use of seclusion and restraint.

ENDNOTES:

[i] See *Encyclopedia of Arkansas*, at this web address: http://www.encyclopediaofarkansas.net/encyclopedia/entry-detail.aspx?search=1&entryID=5196

[ii] Photograph of fence under Creative Commons license from this source: http://creativity103.com/

[iii] "The following procedures apply to 911 patients who do not reside on the Forensic units:

…All patients leaving the unit will be escorted by staff and/or Public Safety Officers to on-campus destinations. **The patient will remain with staff at all times while off the unit."** (*Policy*, at page 2. Emphasis added.)

[iv] The term "peer review" covers independent review by an individual or individuals not associated with the organization reviewed.

[v] Photograph of handcuffs under Klause Creative Commons license.

[vi] *Policy*, at page 5. Emphasis added.

[vii] See Compass Assessment, at page 48.

[viii] Id. Emphasis added.