



# SPOTLIGHT ON **PREVENTION**

Partnering to protect people  
with special needs

## **CASE REVIEWS AND LESSONS LEARNED**

### **Could this happen in your program?**

These case studies, involving fictitious victims, represent a collection of facts identified from multiple Justice Center investigations and are used for illustrative purposes only to aid in staff training and the development of prevention strategies. Each case review includes problems and suggested solutions which can guide agencies in a critical examination of their own operations and actions which may be needed to ensure that the individuals they serve receive appropriate care in a timely manner.



**Justice Center for the  
Protection of People  
with Special Needs**

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## Case #1

Sarah is an adolescent dually diagnosed with intellectual and psychiatric disabilities. She was admitted to an inpatient psychiatric facility and has a history of constipation, which previously required hospitalizations and a nasogastric tube. She is also prescribed Clozapine.

On the third evening of her inpatient stay, at approximately 8:00 p.m. Sarah began vomiting, was experiencing painful cramps and complained of not having had a bowel movement. The nausea and intermittent vomiting continued through the night and into the following morning.

When the pediatrician assessed Sarah at approximately 9:00 a.m. the following morning Sarah was not in any pain and had good vital signs, however she was still experiencing episodes of vomiting. The pediatrician recommended reassessment if vomiting recurred or symptoms worsened.

At approximately 11:30 a.m., a therapy aide attempted to check Sarah's vital signs, but Sarah refused. Sarah did not eat and remained in bed most of the day. These behaviors were atypical; Sarah had good attendance at school, often ate all of her food and was present and engaged in treatment. At 2:45 p.m., Sarah vomited again but staff did not notify the pediatrician for further assessment.

At shift change, not all oncoming evening staff were informed of Sarah's symptoms, while other staff were informed that Sarah was sick, with limited details. Later that evening, a therapy aide took Sarah's vitals. Sarah's pulse was abnormally high, she was extremely lethargic, and she refused dinner. At approximately 7:30 p.m. an LPN checked on Sarah and discovered that Sarah had vomited in her bed and she was unresponsive. The LPN contacted the Charge Nurse for assistance.

The Charge Nurse contacted the on-call doctor, a psychiatrist, and informed him that Sarah was vomiting for approximately 27-hours and had not been eating but didn't share the details regarding Sarah's vital signs and increased lethargy. Due to lack of urgency expressed by the Charge Nurse, the on-call doctor instructed the Charge Nurse to continue monitoring Sarah. Approximately fifteen minutes after the Charge Nurse's contact with the on-call doctor, the Nurse Administrator made a subsequent call to the on-call doctor requesting that he come to the unit to assess Sarah. Upon the on-call doctor's arrival to the unit he was informed that Sarah's blood pressure was not good. He then attempted to take her pulse, but it was weak and ordered the Charge Nurse to call for an ambulance.

When the paramedics arrived, they were not provided with Sarah's medical information or her history of constipation, bowel obstruction and Clozaril therapy. The paramedics were also told that Sarah's distended abdomen was normal for her. The paramedics found Sarah's vital signs and presenting symptoms to be abnormal and transported her to a local hospital via ambulance. A therapy aide from the unit accompanied Sarah to the hospital, however, the therapy aide was new and unfamiliar with Sarah and unable to answer many of the questions that hospital staff asked.

**Sarah died the following day because of complications of an intestinal obstruction.**

### Key Points:

- ▶ **Adolescent with autism and schizoaffective disorder**
- ▶ **Received services on an inpatient adolescent psychiatric unit**
- ▶ **History of constipation**
- ▶ **Prescribed Clozapine—creating high risk for constipation**
- ▶ **Displayed signs/symptoms of constipation, including changes in behavior**
  - ▶ Refusal to eat
  - ▶ Vomiting
  - ▶ Lethargic
  - ▶ Abdomen pains
  - ▶ Lack of stool/incontinence
- ▶ **Although Sarah did not verbally express discomfort, individuals have varying levels of pain tolerance and/or ways of expressing their pain/discomfort, which cannot be ruled out as an indicator that she was fine**

### Overarching Issues:

- ▶ Lack of awareness of constipation and intestinal obstruction symptoms
- ▶ Failure to notify the pediatrician as requested when symptoms returned and worsened
- ▶ Lack of communication between staff regarding Sarah's declining physical condition
- ▶ Unfamiliarity with and failure to follow facility policies and procedures
- ▶ Failure to seek medical attention in a timely manner resulting in delayed medical treatment
- ▶ Insufficient information provided during transfer to emergency responders/hospital

## Case #2

John is a middle-age male who resides in a residential program and requires physical assistance for all activities. John has limited verbal skills; however, he is able to communicate his wants and needs by yelling and gestures. John cannot toilet independently and requires complete staff assistance with his Activities of Daily Living (ADLs). John has a bowel management protocol in place due to a history of constipation.

As part of John's bowel movement protocol staff were required to record John's bowel movements or lack thereof, to contact the residential nurse or on-call nurse if a bowel movement did not occur within a 48-hour time-frame and were provided with directions to administer a prescribed PRN agent at bedtime if John did not have a bowel movement within 48-hours. Nursing staff were to be notified prior to administering the prescribed medication and both the communication with nursing and the administration of medication were supposed to be recorded in the John's Progress Notes, Medication Administration Record (MAR) and nursing notes. Staff were required to continue to monitor John's bowel movement and if after receiving the medication, a bowel movement did not occur by the third day, staff were required to notify nursing immediately to assess John and make a clinical decision as to whether John needed to go to the hospital.

One day, John returned home early from his day program because he was lethargic, withdrawn and not acting himself. John was offered lunch when he returned home, which he did not eat or drink and instead pushed away. John chose to go to his bedroom to lay down. Staff checked in on John throughout the afternoon with no changes observed in John's

state throughout the afternoon into the evening. John refused dinner when it was offered. The residential nurse stopped by the residence in the evening to meet with John, but before assessing John she quickly reviewed his daily bowel chart and MAR. The residential nurse quickly observed that for the three preceding days no entries were recorded in John's bowel monitoring chart and there was no indication on the MAR whether he received his PRN prescribed to assist with bowel movements. Additionally, the nurse was unable to locate recent bowel tracking documentation recorded by staff at John's day program and provided to the residence. The nurse was concerned because residential staff had not contacted her regarding John's absence of bowel movements or administration of his PRN. The nurse spoke with staff on shift, none of whom could recall if they were aware or observed if John had a bowel movement within the past 48-hours.

The nurse immediately assessed John who was sleeping in his bedroom. She checked his vitals all of which were within normal range but based on the lack of completed documentation related to John's bowel movements for the past 48-hours, his lethargic state and refusal to eat/drink, and his history of constipation she took John to the emergency room. **John was admitted and diagnosed and treated for what resembled a partial bowel obstruction.**

Four days following his admission to the hospital John was discharged and returned to his residence. Upon John's return to his residence, his bowel management regimen was re-reviewed due to this recent hospital admission.

### Key Points:

- ▶ **Service Setting: Supervised Individualized Residential Alternative (IRA)**
- ▶ **Diagnoses: moderate intellectual disability, Impulse Control Disorder, and Seizure Disorder**
- ▶ **History of constipation and bowel obstruction**
- ▶ **Had a bowel management protocol**

### Overarching Issues:

- ▶ Staff were not aware, familiar, and/or did not notify nursing of changes in John's behaviors that were possible non-verbal cues indicating constipation
- ▶ Staff were unfamiliar with and/or not adhering to John's bowel management protocol
- ▶ Staff were not completing the required documentation for John's bowel movement management
- ▶ Staff did not notify nursing if/when John did not have a bowel movement in a 48-hour period
- ▶ Insufficient oversight to ensure staff completion of documentation and adherence to John's bowel movement protocol

## Case #3

Jen is a 56-year-old female who has resided in the same residence for approximately eight years and attends a Day Hab Without Walls during the weekdays. Jen is diagnosed with Impulse Control Disorder, Unspecified Bipolar Disorder, Irritable Bowel Syndrome and has a history of Gastroenteritis and constipation. Due to Jen's history of constipation, she had a bowel management protocol which includes a high-fiber, low-sodium diet and prescribed over-the-counter medications for constipation. However, over the past couple of weeks Jen refused to take the medications for constipation.

At approximately 7:30 a.m., the Residential Manager arrived at the residence and was informed by overnight staff that Jen was not feeling well and should stay home from day program that day. Staff reported that in the early morning hours Jen had gone to the bathroom but was straining and unable to produce a bowel movement. While staff was aware that Jen's bowel movements were supposed to be documented, she verbally expressed concern to the Residential Manager about Jen's abnormal bowel elimination, as she typically had a routine bowel elimination in the morning but did not document this. The Residential Manager was later informed that Jen refused breakfast that morning but based on his observations of and interactions with Jen she appeared to be acting herself.

At 9:00 a.m., prior to bringing the residents to their day habilitation programs, the Residential Manager called the residential nurse and left a voicemail requesting a return call. After thirty minutes with no return call, the Residential Manager contacted the Director of Nursing Services to advise her that Jen did not have a bowel movement that morning and refused breakfast. He reported that based on Jen's bowel movement chart her last bowel movement was approximately a day and half ago. To err of the side of caution due to Jen's history of constipation, the Director of Nursing recommended that Jen stay home for the day to rest, take Milk of Magnesia and drink prune juice. The Director of Nursing requested to be updated on Jen's status throughout the morning.

The Residential Manager gave Jen some Milk of Magnesia, which Jen initially took, but then spit the rest out. Jen was then provided with water and prune juice both of which she drank and then went to her bedroom to rest. A few hours later, at 11:25 a.m. Jen got up to use the bathroom. Jen passed urine as well as what

appeared to be diarrhea, but Jen flushed the toilet too quickly for staff to fully observe.

Around 11:30 a.m. the Director of Nursing arrived at the residence to visually check on Jen and review her recent medical documentation. While reviewing Jen's medical records she noticed ER discharge paperwork for constipation issues from two months prior and a recommendation to follow-up with Jen's primary care physician, however, no follow-up appointment was scheduled. A review of Jen's bowel movement tracking documentation since the ER visit revealed several missing entries from staff, and the residential nurse had not completed her required weekly review of the documentation. Additionally, there was no documentation to support bowel movement tracking was used across both of Jen's service providers.

At 12:30 p.m. Jen was still in bed and refused lunch. She went to the bathroom again, this time she eliminated stool that appeared like "loose pebbles". The Director of Nursing visited Jen, who was still laying in her bed. Jen was in and out of sleep, her head did not feel hot to the touch and she didn't express any discomfort. The Director of Nursing departed the residence around 1:15 p.m. and requested that the Residential Manager contact her or the residential nurse with updates on Jen. There were no changes in Jen's symptoms throughout the afternoon when Residential Manager's shift ended at 4:00 p.m..

The Residential Manager informed the oncoming Assistant Manager of Jen's status and that he was waiting for a return call from a voicemail left for nursing that morning. He asked her to keep him and the nursing staff updated on Jen's status.

At 5:30 p.m. Jen again refused dinner and remained in bed. At approximately 7:00 p.m. the Assistant Manager reported to the Residential Manager via text message that she felt Jen's head and believed she had a temperature. At 8:30 p.m. the Assistant Manager sent another text message to the Residential Manager that Jen was not breathing. The Residential Manager immediately called the residence and advised them to contact nursing and call 911. By the time the paramedics arrived, Jen threw up blood and was unresponsive.

**Jen was transported to the local hospital but had passed away due to an intestinal obstruction.**

CONTINUED

## Case #3

### Continued

#### Key Points:

- ▶ **Service Setting: Supervised Individualized Residential Alternative (IRA)**
- ▶ **Diagnoses: Impulse Control Disorder, Unspecified Bipolar Disorder has a history of Gastroenteritis**
- ▶ **History of constipation**
- ▶ **Displayed signs of constipation, including changes in behavior**
  - Refusal to eat
  - Vomiting
  - Lethargic
  - Abnormal stool quality
- ▶ **Emergency Room visit within the past 2 months**
- ▶ **Medical follow up after Emergency Room visit did not occur as recommended**
- ▶ **Although Jen did not verbally express discomfort, individuals have varying levels of pain tolerance and/or ways of expressing their pain/discomfort, which cannot be ruled out as an indicator that she was fine**

#### Overarching Issues:

- ▶ Lack of education/awareness of constipation/bowel obstruction symptoms
- ▶ Staff were not adhering to the documentation for Jen's bowel movement management
- ▶ Residential nurse was not timely in responding to the Residential Manager's call
- ▶ Nursing did not schedule follow-up appointment following ER discharge
- ▶ Lack of urgency in seeking medical attention