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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 08-030-9011
Northwestern Memorial Hospital

Summary: The Human Rights Authority did not substantiate the complaint that the recipient was denied adequate and humane care.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Northwestern Memorial Hospital (Northwestern). It was alleged that a recipient was denied adequate and humane care when she was disrobed by male staff, denied a meal, and told that she would have to clean up after herself. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Northwestern is an academic medical center that provides comprehensive care in nearly every discipline. The Norman and Ida Stone Institute of Psychiatry offers inpatient and outpatient services for adults and older adults with mental health and substance abuse issues. The inpatient facility has 55 beds.

To review these complaints, the HRA conducted a site visit and interviewed the Department of Psychiatry Chairperson, and the Department of Psychiatry Manager. Hospital policies were reviewed, and an adult recipient's clinical records were reviewed with written consent.

FINDINGS

The recipient was contacted for her account of the alleged incidents. She reported that although she could not recall a specific date, she had been disrobed by a male staff person and had been told that she would have to clean herself after she soiled her clothing while sitting in her wheelchair.

The record shows that the recipient was taken to Northwestern hospital involuntarily by the Chicago Fire Department on 7/7/07 after she did not respond to caregivers and a visiting nurse at her home. She confirmed that she was experiencing auditory hallucinations and was cleared within the Northwestern's emergency department before being admitted involuntarily into a locked psychiatric unit (10 West). She had three other admissions in the three months leading to her July, 2007 admission and had a history of schizoaffective disorder and polysubstance abuse.

On 8/7/07 a petition for involuntary treatment was submitted to the court and on 8/22/07 she was court ordered to take medication. On 9/14/07 the recipient was court ordered to a long term care facility.

Psychiatric Progress Notes for the month of July revealed three incidents that relate to the issues:

July 27: "Staff reports: Pt detached her foley bag twice allowing the contents to spill freely onto the floor, creating danger for self and others."

July 28: "Staff reports: Patient had large soft formed bm-dark brown in color- in her wheel chair and floor in her room. She was attempting to clean herself. She did allow staff to assist in cleanup. She continues to laugh and talk to self."

July 30: "Per Nursing, Pt. encountered in dayroom in wheelchair, bedroom door open, ex-large pile formed stool noted in three locations on floor. Pt. gowns soiled. Assisted with hygiene and shower."

Staff were interviewed about these events and stated that generally, all cleanup following these incidents would have been done by staff, not by patients, since patients would probably not be able to sufficiently clean themselves, change their clothing and clean and sanitize the surrounding area. The staff person who was interviewed by the HRA was present at the time the recipient was on the unit, and stated that the recipient's nurse at the time was a female, however if the recipient was resistant to help or the situation required extensive cleanup, additional staff may have been called in to assist. She stated that the general practice is to have female staff assist female patients, however this is a decision based on staffing. In any case, staff stated that a female staff person would always be present if a male staff was involved with the patient in a situation such as this that would involve disrobing. Staff also reported that the recipient was very labile at the time of these incidents and very often she removed her foley bag allowing contents to spill out, and this is corroborated by the record. The complaint regarding the disrobing by male staff might have been her recollection of the cleanup that would have been required after one such event.

The HRA found no evidence to suggest that the recipient was denied a meal. Staff were interviewed about the availability of meals and they reported that even if a patient should miss a meal, that meal would be saved for the recipient for a later time. This is corroborated by the nursing notes which indicate that the recipient had slept through her meal on 7/27/07 and that her tray was saved for later in the evening. Additionally, staff reported that there is a full kitchen available to the patients so that they can access fruit, juice, cereal, crackers and other snacks at any time.

STATUTORY RIGHTS

The Mental Health Code states that a recipient of services shall be provided with adequate and humane care in the least restrictive environment (5/2-102 a). The Code defines adequate and humane care and services as:

> *…services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others.* (5/1-101.2).

CONCLUSION

The complaint in this case alleged that the recipient was disrobed by a male staff member, was denied a meal, and was told she would have to clean herself after she soiled her wheelchair and clothing. After a careful review of the record and interviews with staff, the HRA determined that by all documented accounts the recipient was provided with adequate and humane care whenever she had personal toileting problems. There was no indication that she was ever denied a meal, and the practice is in place for trays to be held for recipients who refuse them at meal times. Also, staff reported that the unit had adequate food available to recipients so that even should they miss a meal, they would have adequate nourishment. The HRA does not substantiate a rights violation.