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North Suburban Human Rights Authority
Report of Findings
Provena Mercy Center
HRA #09-100-9037

Case Summary: the HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below.

Introduction

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Provena Mercy Center. In June 2009, the HRA notified Mercy Center of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation were that within a week of hospitalization, a recipient lost weight and he was unable to chew or close his mouth; the recipient uses sign language as a means of communication and he was unable to communicate due to his deteriorated medical condition.

If found substantiated the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Background

According to its website, Provena Mercy Medical Center is a 356-bed hospital based in the western Chicago suburb of Aurora, Illinois. For more than 90 years, Provena Mercy Medical Center has been the area's leading provider of Behavioral Health Services. Those services include: Addiction, Attention Deficit Hyperactivity Disorder, adult, children/adolescent, and older adult services. The focus of this investigation was the in-patient Behavioral Health program which has 70 beds and a nine-day average length of stay.

Investigative Methodology

The HRA interviewed a family member of the recipient whose rights were alleged to have been violated. The HRA requested the recipient's behavioral health record with written consent; the record was received in June 2009. The HRA learned that the recipient had been subsequently sent to a medical hospital; this record was requested toward the end of July 2009; the record was received in early November 2009. An on-site visit was conducted in November 2009. At the visit the HRA discussed the allegations with the recipient's primary care medical and mental health physicians, the Regional Director, and the Risk Manager. The HRA acknowledges the full cooperation of all hospital personnel.

INVESTIGATIVE FINDINGS

Summary of information obtained from the family member

During the interview with the recipient's family member (who is the Power of Attorney agent), it was explained that the recipient is a 28 year-old male who had contracted renal failure as a child. He underwent two Renal Transplant operations, one in 1992 and another in 2003. He was restarted on hemodialysis in January 2008. In February 2008 he was struck on the head and sustained a severe head injury with resultant Right Hemiplegia and aphasia. The recipient is paralyzed on his right side and cannot speak.

The family member explained that the recipient was subsequently admitted to a nursing home (located on Provena Mercy Center campus) following the head injury. On a visit to the nursing home on April 26, 2009, the family member stated that the recipient was alert and lucid, he was playing cards and he was able to feed himself with his left hand (his food needed to be precut). The family member explained that the recipient could chew and swallow his food even though he had difficulties with his tongue.

The following day, April 27th, the recipient struck a nurse who was giving/checking a second TB (Tuberculosis) test. The recipient was then transferred to BHS (behavioral health services) because he posed a danger to others.

The family member stated that when he visited the recipient on May 2nd and 3rd, he did not recognize him. He stated the recipient was slumped over and "drooling". There was a tray in front of him with one bite taken out of a hamburger. The recipient was unresponsive to the family member's questions and he could not hold himself erect in his wheelchair. The family member informed the nursing staff that "something was wrong". The following day (May 3rd) the recipient was "glassed over" and he had difficulty communicating both with his communication board and with hand signs, and he was "dizzy".

The family member stated that on May 5th he received a call from the Provena Medical Center's Emergency Department saying that the recipient had been admitted. The family member learned that the recipient had been discharged from BHS to the nursing home; the nursing home then (2 ½ hours later) sent the recipient to the emergency department.

Summary of the BHS record

The recipient signed a voluntary admission application on April 27, 2009; admission orders list the recipient's father as having Power of Attorney for Healthcare. The History and Physical document describes the recipient as a 28 year-old- male with a past medical history of aphasia, right-sided weakness, traumatic brain injury, history of end-stage renal disease on hermodialysis, history of pulmonary hypertension, and history of glomerulonephrtis. He was sent from a nursing home on April 27, 2009 due to increased agitation. The recipient was noted to be alert, awake, orientated (2x) with no acute distress. The discharge summary stated that during the hospitalization the recipient had episodes of agitation when he needed P.R.N. (as needed) medication, but that his mood gradually improved. He was compliant with treatment and medications and during the last 36 hours, he had no episodes of agitation so he was discharged. The HRA noted that the medication form was not signed by the recipient or the Power of Attorney agent. The psychiatric examination noted that the recipient gets easily angered and easily frustrated when he cannot communicate. The record showed that the recipient used a type-and-talk communication device which was brought over from the nursing home shortly after the BHS admission. The record showed that the recipient would and would not use this device to converse with staff members. The last notation regarding using the

communication devise was on 5/3 at which time it was documented that he spoke to staff with his communicator. Documentation showed that he would also use sign language to communicate.

The recipient had a recorded weight of 145 lbs.; it was noted that he had difficulty chewing. There are records of the percentage of food consumed for 14 (out of a possible 21) different meals during his admission. Three reported 50%, six 25%, and five 0% of his meals were consumed. During the last two days of his admission (5/3 and 5/4) – there is no recorded intake (0%) in the dietary record; progress notes show that he refused the meals on these days. On May 2nd one meal is recorded which indicated that he ate 25% of the breakfast meal. The ranges regarding how the recipient tolerated the diet were "poor", "fair" and "well". On 5/3 it was documented that he "has not had any difficulty swallowing tonight."

The record indicated a general trend of a decreased level of responsiveness during the hospitalization. For example, while he was doing a woodworking project (4/28), he is described as "active….painting…. sanding". On 5/1 while working at the same project, he is described as "staring off into space…. needed prompting". On 5/4 documentation noted that he "Rang his bell throughout the night…does not know what he needs… alert to person only". On 5/4 he did request to get up for breakfast but did not eat; it was documented that he propelled himself back to his room. Prior to his discharge he is described as "sedated and fatigued". There is nothing in the chart to show that the recipient and/or the family member brought any concerns about the recipient's medical condition during this hospitalization.

Summery of the Emergency Department Record

The recipient was admitted from the nursing home to the ED at about 5:30 p.m. on 05/04/09 for low blood pressure (BP) and a rapid heart rate. He had been released the same day from BHS. According to chart documentation, the recipient appeared to be lethargic and he was responding to his name only. His vital signs were: BP 86/46 (low), pulse 112 (high), respiratory rate 24 (high); he was afebrile. Blood work-up showed Creatinine 10.7 (high), Potassium 6.6 (high), and Blood Urea 90 (high). His white cell count was 15.0 (high) with a left shift, indicating infection. Charting indicated that 20cc of cloudy tea-colored urine was drained from his bladder with 3+ Bacteria which lead to a diagnosis of "Sepsis secondary to Urinary Tract Infection". The recipient was treated with glucose and insulin to reduce his elevated Potassium, Antibiotics for his UTI, and Levophed to restore his BP. He was admitted to the hospital at about 1:15 a.m. 05/05/09. His weight at the time of the medical admission was 138 lbs.

Summary of History and Physical Policy

The policy states that a History and Physical (H/P) examination will be completed within twenty-four hours of an inpatient or outpatient admission. The psychiatrist will identify by name the physician who will complete the H/P and do medical follow-up with special attention to managed care guidelines.

Summary of site visit

The psychiatrists stated that their purpose was to stabilize the recipient so that he was no longer aggressive, and to that end they accomplished their goal. It was stated that if he had shown overt signs of medical complications, they would have enlisted the help of the physician who conducted the admitting history and physical. The physician who conducted the initial

History and Physical told the HRA that he did not see the recipient after this initial assessment, since there was no need. Had he received a call from the BHS personnel reporting a medical problem, he would have done an examination. The psychiatrist stated that at times the recipient did not communicate with him, but he stated that this is common and he found no need for concern.

Since the HRA found no record of any action taken by the staff in regard to the dietary intake, it was asked what happens with the collected data. It was explained that once the BHS learned that the recipient had been admitted to the ED, an internal audit of his chart was made. It was stated that following that audit, staff members now must report missed meals to the dietary department so that a nutritional assessment can be made. When asked about his recorded weight, it was stated that it was not documented if this was an actual or a reported weight.

Conclusion

The Mental Health Code prohibits negligence, which is the failure to provide personal maintenance resulting in physical or mental injury or deterioration, and requires that all care be adequate and humane (405 ILCS5/2-112, 5/1-117.1, and 5/2-102).

Section 3-205.5 of the Mental Health Code mandates that the facility provide or arrange for a comprehensive physical examination, mental examination, and social investigation of the person being admitted.

Since it is unclear whether the admission weight of 145 lbs. was an actual or a reported weight, the HRA can neither prove nor disprove the assertion that the recipient lost weight during the hospitalization. Charting indicated that he had not eaten during the last two days of the hospitalization. Charting documented that he refused the meals, and it was noted that he did not have difficulty swallowing on 5/3. However, this notation that he had no difficulty swallowing implies he had difficulties at other times which were not documented.

The recipient used the communicator on 5/3; thus it is concluded that he was communicating with staff members at least on the day before discharge. The HRA does not substantiate the stated allegations but does offer the following suggestions: admission weight must be documented as actual weight; refused meals must be addressed in a timely manner; recipients with noted swallowing/chewing difficulties should be addressed/monitored on a regular basis.

Suggestion

Section 2-102 and 2-107 of the Mental Health Code states that if services include the administration of psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. And, the physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the proposed treatment. If the recipient lacks capacity, the proposed treatment may only be given to prevent serious and imminent physical harm when no less restrictive alternative is available. The chart did not document the recipient's decisional capacity. The hospital must ensure that their physicians determine and state in writing whether the recipient has the capacity to make a reasoned decision about treatment. Per the record, no one provided informed consent for the psychotropic medications and their proposed doses. Best practice dictates that medication consent forms contain the signature of the recipient and/or recipient's substitute decision maker.

Comment

The HRA cannot ignore the fact that this recipient was a sick patient by the time that he arrived at the ED, needing emergency intervention for his renal failure, antibiotics for his infection, and support for his low BP. It seemed that the staff from the nursing home immediately recognized the fact that he was very sick. We leave medical determinations in physicians' hands although in this case we question whether his deteriorated condition did not seem to be appreciated by the staff at the BHS.