FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Alexian Brothers Medical Center
HRA #09-100-9042

Case Summary: the HRA substantiated part of the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Alexian Brothers Medical Center. In August 2009, the HRA notified Alexian Brothers Medical Center of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint investigated was that a patient received substandard care because his chart showed that he has a schizophrenia diagnosis. For example, nurses were not monitoring his medical needs, he was not being regularly ambulated, he was put in restraints without justification, he had open sores on his ankles and wrists, and he was discharged with pneumonia. In addition, as a result of the restraints being applied too tightly, he received cuts on his limbs. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and under the Code of Federal Regulations for Medicare/Medicaid participation (42 C.F.R 482).

The HRA conducted an on-site visit in November 2009. While at the hospital, the HRA interviewed representatives from administration, risk management, nursing personnel and the hospitalist program. The HRA interviewed a family member of the consumer whose rights were alleged to have been violated; and with written authority, the consumer's clinical record. Also reviewed were hospital policies relevant to the allegations. At the site visit the HRA was advised that an internal Quality and Patient Safety analysis was conducted; the results of the analysis were given to the HRA for review.

Background

Alexian Brothers Medical Center is a 320-bed community hospital located in Elk Grove Village. The hospital has more than 750 physicians on the medical staff representing over 60 medical and surgical specialties. Alexian Brothers Medical Center has earned the Joint Commission's Gold Seal of Approval for Disease-Specific Certification as a Primary Stroke Center, in Heart Failure, Acute Myocardial Infarction, Bariatric Surgery, Joint Replacement and Oncology. The hospital contracts with a Hospitalist program. Hospitalists are physicians trained in general internal medicine and/or family medicine who devote their practice to the care of hospitalized patients.

In researching the Hospitalist program, the HRA learned that the hospitalist movement began in the United States in 1993. The hospitalist program offers referring doctors the assurance that their patients are receiving the highest level of care during an inpatient stay while easing the load of continuous visits to the hospital. By devoting their practice to the care of hospitalized patients, hospitalists concentrate on the unique aspects of patients' needs during their hospital stay, working

with nurses and other caregivers at the Hospital to provide an integrated patient-care team. In the same way a cardiologist specializes in the care of heart patients, a hospitalist is a medical physician who specializes in the care of hospitalized patients. Since hospitalists do not maintain an office practice, they focus exclusively on patients in the hospital setting and are highly skilled in caring for the critically ill.

Investigative Findings

Allegation: a patient received substandard care because his chart showed that he has a schizophrenia diagnosis; nurses were not monitoring his medical needs, and he was not being regularly ambulated

Information obtained from family member

The family member stated that on June 10th, 2009 (Wednesday), the patient went to the hospital for a same day surgery bone graft. The family member explained that in 2002 the consumer had broken his hand and had a bone graft in 2008; the graft was taken from his wrist. For this graft, it would be taken from the hip. The last time the procedure went well and he was out of the hospital the same day. It was stated that they were advised that for this procedure he would most likely be kept for 23 hours. However, due to the need for pain management he was admitted. The family member explained that typically when the consumer initially sees a doctor, she does not disclose his schizophrenia diagnosis because he is treated "differently". She did say that for this hospitalization, she advised the hospital of the diagnosis and what medications he was taking for the schizophrenia.

It was stated that he returned from surgery with an IV pump for pain. He tried to urinate afterwards but was unsuccessful so a Foley catheter was put in place and a large amount of urine was collected. The family asked hospital staff if they kept an Intake and Output chart after surgery and they replied that they did not. On Thursday a day nurse called her because the patient was "scared" because of chest pains; she learned the pains started during the evening and questioned why a night nurse had not called her earlier. When she arrived at the hospital, the patient was not sleeping, not eating, and the pain medication was not helping. She stayed overnight and noticed a rash all over his chest and arms. This had not been noted by the staff. On Friday she said the patient was not eating and he had not been out of bed. She was told that a Movement Team would come to assist him out of bed. She said she never saw a Movement Team.

The family member noted several times during the discussion that there were so many physicians caring for the patient that she did not know who was doing what.

Information obtained from the clinical record

According to the clinical record, the patient is a 49-year-old male with a nondisplaced left middle finger metacarpal who underwent removal of hardware and repair with bone graft on June 10, 2009. He was subsequently admitted for pain management; admitting documents indicate a schizophrenia diagnosis. It was documented that postoperatively the patient developed some abdominal pain, abdominal distention, and a postoperative ileus. He was discharged on June 15, 2009. The patient received the following consultations during the course of the hospitalization:

- 6/11/09 assessed for post operative pain management
- 6/12/09 Portable chest x-ray.
- 6/12/09 CT **(**computed tomography) scan of the chest, abdomen
- 6/12/09 Right upper quadrant ultrasound due to abdominal pain, liver normal, gallbladder sludge, pancreas normal.
- 6/13/09 Consult Surgery—seen for abdominal pain (ileus) and Gallbladder sludge

- Date of consult or type of consult not listed (Date dictated 6/13/09) – In remission for lymphoma, history Schizophrenia. Assessed abdominal pain. Appeared to be resolving. Asymptomatic gallbladder sludge. No treatment at this time, increase diet slowly as his ileus has started to clear, monitor symptoms.
- 6/13/09 psychiatric evaluation
- 6/13/09 Portable chest x-ray.
- 6/13/09 kidney, ureter, and bladder (KUB) x-ray. (The HRA notes that the Physician's order (6/12/09 at 8:15 a.m.) is written for **stat** KUB R/0 obstruction. The x-ray was done the next day 6/13/09, report dictated 12:53PM).

At the site visit, the HRA received an Input & Output printout for the course of this patient's hospitalization. The chart did not indicate the amount of urinary output. The chart did not show any oral input, except for meals which were documented according to the percentage consumed. Only six meals were charted which showed a range of poor (0-24%) to very good (75-100%) appetite. Documentation showed three times of NPO (nothing by mouth) status.

According to the Patient Activity Chart and nursing note documentation, the patient was dangled/walked two to five times each day. (Dangle is the first movement a patient is allowed, either after surgery under general anesthesia, where the patient allows his/her feet to dangle over the side of the bed). Charting showed the minutes he was dangled (5 to 20 minutes) and the distance he walked (10 to 150 feet). The physician's order states to ambulate the patient with assistance.

Information obtained from hospital personnel

The HRA began the interview by asking hospital personnel to explain the hospitalist program. One Physician at the meeting explained that she was the physician on duty when this patient was admitted Wednesday June 10, 2009 so she was considered the Primary Physician. The patient's orthopedic physician wanted the patient to be hospitalized; this physician is now the Consulting Physician. The Primary Physician explained that she works 7:00 a.m. to 5:00 p.m. and she had 36 patients on the day we spoke to her. There are other physicians that work 5:00 p.m. to 7:00 a.m. and the physicians will conduct *doc-to doc* reports when needed.

The Primary Physician went on to explain that the patient was at the hospital for day surgery on his left hand and due to his pain he was admitted to the hospital. During the course of hospitalization he developed abdominal and chest pain. Various tests were done, consultations by the pain nurse practitioner (she is employed by the hospital and is under the anesthesia department), a surgeon and a psychiatrist (he is in practice with patient's psychiatrist). Another physician, who was also at this meeting, took over as the Primary Physician for the weekend. This Physician wrote the Discharge Summary dated Monday, June 15, 2009.

The Primary Physician stated that in looking back, she would have automatically put the psychiatrist on hand to evaluate the combinations of medications and medications reactions. The patient had PCA (Pain Controlled Analgesia) and a Block. It was explained that as the Block wears off there is tingling and it is painful.

The night nurse told the HRA that he knew the patient had a schizophrenia diagnosis but he did not feel that the patient was different than other patients. Nursing personnel said they treated this patient as any other patient and did not consider the psychiatric diagnosis when considering how to care for the patient.

Regarding the allegation about ambulation, it was reported they have a Mobility Team that they can use to walk the patient about one time per shift, but usually it is the nurse assistant who does this. It was stated that ambulation is simply part of the everyday routine for all patients.

Allegation: he was put in restraints without justification, he had open scores on his ankles and wrists, as a result of the restraints being applied too tightly, and he received cuts on his limbs.

Information obtained from family member

The family member stated that on Sunday at 2:00 a.m. the hospital called to say that the patient had been placed into restraints (the family member was the primary family contact). It was at this time she heard a female staff member say to another staff person that "he was schizo and I can't deal with it". Again she mentioned she does not make known about the schizophrenia because of the reaction of people. The patient sees a psychiatrist every 6 months for 15 minutes of medication management. When she got to the hospital she wanted to take him to the bathroom; when she pulled back the covers she noticed that the restraints were still on his wrists, ankles and he was in a vest. The staff allowed her to untie the restraints from the bed but they were left on his body. It was at this time she noticed he had sores on his wrists and ankles. On Sunday, after the restraints were removed, he was given a sitter.

Then she showed the HRA pictures she had taken with her cell-telephone. The pictures included: blood on restraints, right hand sore, elbows sore, ankles sore, ear sore/, blood on pillow case, cast on left hand with the outer covering disturbed. The staff did not know about the "sores" as she referred to them on his body. She showed another picture of an abrasion on the top of his right hand which she thought was from rubbing on the sheets and a picture of his left elbow which showed a red mark from what she said were also from the sheets.

Information obtained from the clinical record

According to the medical record, on June 13th the patient was given a psychiatric evaluation. It was documented that the evaluation was requested because of increased agitation and confusion. The psychiatrist documented that the patient had been stable for about 20 years; when he came out of surgery he was put on a PCA pump of Dilaudid (pain management) but the patient started becoming increasingly disorganized, confused and he tried to get up out of bed, pulling at some of his tubes and wires and he had to be redirected. The psychiatrist documented that the patient was given Ativan and seemed to be a bit aggressive and threatening during that time. The Plan was to use Haldol as it appeared "that Ativan was not particularly useful and may be exacerbating his confusion."

On June 14th at 2:10 a.m., restraints were applied as the patient continued to be increasingly agitated and confused. It was documented that he attempted to strike staff; he was hitting his arm and pulling at the wound dressing. At 7:30 a.m. a *Mr. Strong Code* was called because the patient was out of control and his speech was garbled. He was placed in soft restraints for protection of self. The charting noted that the patient's family member had refused medication for the patient earlier that morning, stating that "Its not a psych issue it is something else." Documentation indicated that the patient's breathing was labored; he was agitated and very restless. Three doctors were subsequently updated. Documentation showed that the restraints were "off" at 1:30 p.m. on June 14th. However, it is unclear if this means that the restraints were united from the bed and/or removed from the patient's limbs. A sitter was noted to be at the patient's bedside at about 11:00 a.m.

On June 15th at 11:20 a.m. a psychiatrist notes that the patient was sleepy, he had slurred words, and he was up walking in halls with wife and sitter. He was observed to be slightly restless, no agitation noted, no confusion noted. It was documented that the patient's wife voiced concerns about the patient having been in restraints and says he has rub wounds on wrist and ankle.

According to the restraint record, there is one page for "Impaired circulation related to restraint". The list showed that the circulation was not impaired, with the exception of one notation (6/14/09 4:30 a.m.) which noted that that the circulation was impaired. Another page is just for

"Impaired skin integrity related to restraint"; each noted observation (2:30 a.m. to 12 p.m.) all indicated that the skin integrity had not been impaired.

On the day of discharge the Psychiatric Nurse Practitioner charted that, "Pt's W [wife] hopes pt can go home today. She voices concern re patient having been in restraints & says he has rub wounds on wrist & ankles." The HRA notes that she does not say she looked at the wounds. Discharge documents indicate "non-raised, upper left arm improving, abrasions left elbow no change, abrasion left ankle no change".

Information obtained from hospital personnel

The night Nurse explained that the patient was disorientated and restless; staff members walked him up and down the hallways. The patient wanted the Foley out so an order was subsequently obtained and the Foley was removed. The Nurse reported to the HRA that the patient was unsteady, he was hitting his left arm on the bed side-rails, and he was striking out with the left arm. The Nurse said that he did not think the patient realized he was in the hospital, but the patient did want to leave. At one point the patient was observed to be very disoriented (walking behind his bed, walking into the wall); the night Nurse then asked for help from the Nursing Supervisor.

In an effort to keep the patient safe, the Physician was contacted for an order for restraints. The nurse recalled that he first tried a Posey vest. At some point he applied the arm and leg restraints to help the patient stay in bed. It was questioned if specific restraints were ordered and they were not - the order states "restraints okay". The Medical and Surgical Restraint Order form does not document the clinical justification for the restraints. Under the Less Restrictive Alternatives section, which included measures such as a family/sitter, verbal reorientation, bed alarms, frequent observation, 3 siderails up; nothing was checked to denote that less restrictive measures were attempted. The nurse did say that less restrictive measures were tried such as the walking in the hallways and verbal reorientation.

It was then discussed whether this was a Medical Surgical Restraint or Behavioral Restraint. The Nurse stated that he later learned that once he applied the 4 point restraints to the arms and legs it became a Behavioral Restraint. The day nurse told the HRA that when the restraints were untied from the bed, she documented that they were removed but she should not have done so because the restraints remained on him. At the end of the restraint discussion, hospital personnel commented that they use restraints as a last resort.

The HRA notes that the internal investigation showed that the Medical Surgical restraints were used when 4 point restraints were initiated. This analysis documented that this should always be behavioral health. The Follow Up says "Educate CPC's on use of behavioral vs medical surgical restraint. Revise med surg restraint flow sheet to indicate when placing four point restraint then behavioral restraint should be initiated."

It was stated that the Rapid Response Nurse was called, and this nurse checked the restraints and noticed right away that the right wrist restraint was too tight; it was adjusted and it was noted that the skin was red. A Rapid Response Nurse is called when a med/surg nurse determines a patient meets at least one of the following criteria: acute changes in heart rate, blood pressure, consciousness and other vitals. If the nurse observes one of these signs or simply has a gut feeling the patient's health may be deteriorating, even without outward evidence, she/he calls the Rapid Response Nurse.

Regarding the wife's concern made to the Psychiatric nurse, the HRA inquired if the Nurse should have checked the patient for the abrasions. Two hospital members responded to the inquiry - one by saying that they would hope that the patient would be checked for an abrasion; the other response was that if staff were told this, they should have looked. The nurse who discharged the patient mentioned she noticed he had an abrasion on his elbow.

The HRA notes the number of physicians involved and medications that were given during the restraint event. An Internist ordered two medications, and then a repeat of one of the medications. The patient's psychiatrist ordered two more medications and the Psychiatrist's Associate ordered two other medications - all within a two hour period. The psychiatrist Associate noted in the psychiatric evaluation (the previous day) "that Ativan was not particularly useful and may be exacerbating his confusion.", yet he ordered Ativan. The 6/14/09 MAR noted that the Dilaudid was to be held as it was "causing confusion". The HRA notes that there was not an order on the physician's order sheet to hold the Dilaudid. It was also mentioned that Dilaudid can cause urinary retention.

Hospital policy

Hospital policy states that restraints and/or seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or to others, never to punish or discipline, or for the convenience of staff. They are used only when less restrictive measures have been tried and proved unsuccessful, clinical justification for the use of restraints and/or seclusion include: Acute Medical and Surgical: to prevent falls or injury in high risk patients; to maintain integrity of medical treatment, such as tubes, and injury to self related to neurologic changes associated with the medical diagnosis. The clinical justifications for behavior management are: danger to self - active self-mutilation, active suicidal ideation with the inability to contract for safety, and risk of elopement. Danger to others - physical aggression and/or threats toward others, confusion, wandering, and/or intrusive behavior that pose a risk to others and the environment and 4 or 5 point restraint regardless of the justification for the restraint initiation.

Allegation: a patient was discharged with pneumonia.

Information obtained from family member

The family member reported that on Friday (6/12/09) the patient was not eating and he had not been up out of bed and she learned that he had pneumonia. When questioned if he had ever had pneumonia before or any other lung problems she said no. She said they were not telling her what was going on but she did say that she was told his magnesium and potassium were low and he was given those medications.

Information obtained from the medical record

According to the medical record, at the time of admission the patient's Respiratory Assessment was WDL (within defined limits), breathing pattern was regular, chest expansion symmetric, unlabored effort, breath sounds clear and equal. On June 12, 2009, a progress note lists Pneumonia and an antibiotic was ordered. At the time of discharge his breathing sounds were documented as clear and equal, no cyanosis, dyspnea, cough.

The HRA reviewed a print out for the patient's "Incentive Spirometry" (a medical device used to help patients improve the functioning of their lungs after anesthesia/surgery). According to this print out, in the three days following the surgery, it was used five times.

Information obtained from hospital personnel

The Primary Physician did not believe the pneumonia was a post operative complication. It was noted that he had a fever after the surgery, but it was explained that this is common in orthopedic surgery. They did not culture any bacteria since there was no evidence that he was coughing up any sputum. The combination of the temperature elevation, High White Cell Count and change in his Chest x-Ray was enough to justify the diagnosis.

When asked if the hospital had a method to track post-operative pneumonias, it was stated that only ventilator associated pneumonia is tracked.

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). Abuse, which is any physical or mental injury inflicted on a recipient other than by accidental means, is prohibited under the Mental Health Code (405 ILCS 5/2-112, 5/1-101.1).

The Mental Health Codes states that restraints may only be used therapeutically to prevent physical harm or abuse and only upon written order and accompanying restriction notices (405 ILCS 5/2-108). The Code of Federal Regulations adds that all patients have the right to be free from restraint of any form imposed as a means of coercion, discipline or convenience and may only be imposed to ensure immediate physical safety (42 C.F.R. 482.13)., and all forms of abuse or harassment are prohibited under the Code of Federal Regulations (42 C.F.R. 482.13).

Based on the information obtained, the HRA concludes that the patient did not receive substandard medical care because his chart showed that he has a schizophrenia diagnosis. The clinical record showed that nurses were monitoring his medical needs and verbal accounts were that the mental health diagnosis did not come into play when medical needs were determined/administered. Regarding the assertion that the patient was not being regularly ambulated, the HRA concludes that he was being ambulated.

According to chart documentation, the patient was placed in restraints for his safety; thus the restraint application was justified. However, staff members failed to follow hospital policy when the four-point restraint was initiated, thus making it a behavioral health restraint. And, chart documentation was lacking, in that the removal of restraints was not denoted correctly.

There is some charting that the patient's limbs might have been compromised with the use of the restraints. The Rapid Response Nurse noted that the right wrist restraint was too tight. The pictures from the family member showed open sores on his ankles and wrists. The HRA finds a substantiated rights violation regarding the application and monitoring of the restraints.

Hospital personnel acknowledged that the patient did not have pneumonia at admission. The patient was discharged with pneumonia, but hospital personnel did not acknowledge that this pneumonia was a consequence of the hospitalization. We leave medical determinations in physicians' hands although in this case we question whether the pneumonia – and the Paralytic Ilius were the result of the patient's hospitalization.

Recommendations

1. Hospital personnel must be trained in the use of both medical/surgical and behavioral health restraints. Staff members must also be trained in the monitoring and documentation difference of each category of restraints.
2. The hospital must ensure that Physician's orders are carried out as ordered.
3. Documentation must show all reported medical complications, including alleged injuries, and what was done upon receiving said report.

Comment

The most concerning situation for the HRA and the family member was the large number of different physicians who were involved with this patient's care – all of whom were able to prescribe medication. It was not clear that there was any effective communication between the physicians regarding his care. And, it appears that there was no one person in overall charge of the patient during his hospitalization. Also, the HRA questions the family member refusing medication on the patient's behalf - unless the family member had a legal responsibility to provide consent or she was clearly considered the patient's surrogate, the refusal must come from the patient.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

ALEXIAN BROTHERS
Medical Center

March 23, 2010

Dan Haligas – Chairperson
North Suburban Regional Human Rights Authority
Guardianship & Advocacy Commission
Legal Advocacy Service
Office of the State Guardian
9511 Harrison Street
W-300
Des Plaines, IL 60016-1565

Re: Response to the Findings of the North Suburban Regional Human Rights Authority, HRA # 09-100-9042

Dear Mr. Haligas:

In response to the recommendations and comments subsequent to your investigation in November, the following actions have been initiated at Alexian Brothers Medical Center:

Report Recommendations:

1. "Hospital personnel must be trained in the use of both medical/surgical and behavioral health restraints. Staff members must also be trained in the monitoring and documentation difference of each category of restraints.
2. The hospital must ensure that the Physician's orders are carried out as ordered."

The hospital policy related to the use of the restraints was revised to assure compliance with the Joint Commission Standards and CMS requirements. (See attachment.) We also report restraint use to the Utilization Committee on a monthly basis.

Furthermore, a Nursing Competency Fair held on February 25, 2010 included education about the new Restraint Policy, the documentation requirements, the physician order requirements and a "hands on" return demonstration on application and removal of restraints.

3. "Documentation must show all reported medical complications, including alleged injuries, and what was done upon receiving said report."

A house wide presentation on Managing Risk, which will target nursing documentation, will be presented on March 26, 2010 and October 22, 2010. (See attachment.)

800 Biesterfield Road, Elk Grove Village, Illinois 60007
847.437.5500

There is a monthly random selection of medical records that are presented at Nursing Peer Review Committee to assure appropriate documentation and compliance with Restraint Policy.

Report Comment:

- Ineffective communication among the various physicians involved and no one physician in overall charge of the patient during the hospitalization.

The Vice President of Medical Affairs has sent a letter to the physicians involved detailing your comments.

Thank you for the opportunity to respond. If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

ALEXIAN BROTHERS MEDICAL CENTER

John Werrbach
President/CEO

JW:kp
Enclosures