FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Report of Findings
Case 10-060-9004
Decatur Memorial Hospital

The East Central Regional Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning health services at Decatur Memorial Hospital located in Decatur, Illinois:

1. Care is inadequate in that a patient contracted an infection while receiving treatment in the hospital. The infection was not addressed by hospital staff.
2. Hospital staff and a physician did not interact with the patient appropriately regarding her disability.
3. Treatment may not have been appropriate for the individual's condition.
4. A patient did not receive adequate hydration and nutrition.
5. The patient's personal health information may not have been protected.

If found substantiated, the allegations represent violations of the Hospital Licensing Requirements (77 Ill. Admin. Code 250), the Hospital Licensing Act (210 ILCS 85), the Medical Patient Rights Act (410 ILCS 50) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Decatur Memorial Hospital (DMH) consists of 341 beds, 32 of these are for the intensive care unit (ICU). Per its website it states: "We are committed to providing outstanding medical service to further our mission of improving the health of the people of Central Illinois. By combining a highly trained staff of professionals with the latest advances in state-of-the-art technology, DMH provides proven quality healthcare."

Complaints:

According to the complaint, a patient with a developmental disability was hospitalized on 4/21/09 for tests to determine a course of treatment regarding a mass in her lower abdomen. Staff were reportedly aware that the patient would need assistance due to her disability in ordering food and drinks. This patient was found very thirsty without anything to drink around 6:00 pm in the evening. The dietary unit called to ask what the patient wanted for dinner. Her guardian answered the call and explained to the dietary unit that the patient had a tray of food by her bedside. The dietary unit let the guardian know that the food on the tray was from lunch. Then the guardian allegedly helped the patient order food for dinner and something to drink.

There was good evidence that the food beside the patient had sat there a long time because it was cold to the touch. It had been explained to staff that with this person's disability she would need to be checked on periodically because she did not have the ability to use the call button.

The complaint states that on 7/20/09 the patient was hospitalized again to have a hysterectomy and to ascertain the mass in her lower abdomen. After the procedure, the patient had to be put in the intensive care unit (ICU) instead of recovery due to severely low oxygen levels. When consent was requested from the guardian to put the patient on a ventilator the guardian asked the physician if the patient had been given too much anesthesia.

The response from the physician was reportedly that the patient has three things going against her: She is mentally retarded, she was in respiratory failure and she has severe kypho-scoliosis which impedes her ability to take deep breaths. The guardian learned at that time the patient's carbon dioxide (CO_2) level was 90+ after the surgery. The guardian was also told by the physician since there was no DNR he would put the patient on a ventilator with or without consent if needed.

Her prognosis for recovery after surgery was uncertain. The guardian was told she could go either way as far as surviving the surgery. When another visitor came to visit the patient and walked up to the ICU, she could find no staff. When she finally tracked down a staff member and asked about the patient, the nurse responded she is right over there and pointed to the patient. The nurse reportedly walked away, she did not ask who the visitor was or check if it was ok for this person to be visiting this patient. During the course of the patient's stay in ICU, two of the visitors had to help the patient get into bed because they were informed that both nursing staff who were certified nursing assistants (CNA) (the only nursing staff on ICU) was pregnant and unable to lift a patient.

Per the complaint, the guardian had to register the patient three times when the guardian was signing the documents for admission; she was told that her blue ink was not legal for her signature on hospital documents. The guardian explained that the blue ink was an indication of an original signature. The staff's response was reportedly as follows, "I'll have to make a note of that so they won't think I'm retarded." The patient who has a cognitive impairment and was sitting next to the guardian could clearly hear the staff member's comment.

Before discharge from this hospitalization, the guardian requested that the patient be tested for a urinary tract infection (UTI). The patient had bright red blood dripping to the foley catheter. It was expressed by hospital staff that this was normal. None of the physicians that interacted with this patient at the hospital would order the test. So when the patient arrived at the nursing home directly after the discharge, the guardian requested the test and the patient tested positively for a UTI. It was determined that the patient contracted the UTI while she was receiving treatment at the hospital.

INVESTIGATION INFORMATION

Interviews:

The HRA proceeded with the investigation having received written authorization to review the patient's record. To pursue the matter, the HRA visited Decatur Memorial where the hospital representatives were interviewed. Relevant practices, policies and sections of the patient's record were reviewed; an HRA investigation team met with and interviewed the administrator, the risk manager, hospitalist, vice president of medical affairs, one of the physicians and the vice president of nursing.

The HRA asked what information was provided to recipients during the admission process. Hospital staff explained that admission information was provided including rights information. It was explained to the HRA that the hospital had a system in place to check on someone if they did not order a meal by a certain time. It was also explained that this patient's lunch meal on this date might have been delayed due to the patient having a procedure and lunch might have arrived at later than the usual time. As far as someone checking on the patient who has a disability, it was explained that nurses make hourly rounds usually handing off rounds between the nurses and nursing assistants. On some units, rounds are even more frequent. The rounding schedule should have prevented the patient from going for a long time without anything to drink and food that was safe to eat. There is a system in place that if a meal is not ordered, a patient should be contacted by dietary.

When asked about staffing in the ICU, the HRA was told that normally staff are in the room checking on the patient. The majority of staff are registered nurses (RN's). There are three different intensive care units with 10 beds in each one. One is specifically for cardiac patients and one is for surgical patients. There is usually one nurse for every two patients. There are also licensed practical nurses (LPNs) and CNAs. There would also be a unit secretary, respiratory therapist, case managers and physicians coming in and out of the unit. It would be extremely unusual to not have someone in the unit.

The HRA team inquired about admitting a patient with disabilities and addressing any special observation and monitoring needs. The response was that generally all rooms are completely visible from the nursing station. Nurses are responding to multidisciplinary patient diagnoses, specific diets, and completing rounds in multiple disciplines. There is nurse-to-nurse hand off once an hour rotating between the nursing assistant and the registered nurses. Some units have more frequent rounds. The rounding schedule should have prevented the patient from going without something to drink or eat. Staff should have been able to meet any accommodations made for individuals with disabilities in regards to dietary needs, treatment by caregivers, and treatment. The patient was on the bi-level positive air pressure (BIPAP) machine which needed to be checked regularly.

The protocol for visiting a patient in ICU is open access. There is one nurse for every two patients. All ICU units are visible from the nurse's stations. Guests are encouraged to limit stays to every 10 minutes. The HRA asked why there were no staff available to provide lifting to patients. Staff explained to the HRA that there were all sorts of equipment to move the patient. There was a complete lift to assist the patient to sit, stand, and transfer. Staff should have been available to help move the patients.

The HRA asked why the patient was not tested for a UTI when the guardian requested it. Hospital staff explained the patient was tested and it was negative. Several tests were given and the patient had a normal white blood count at discharge.

Regarding the comment "I'll have to make a note of that so they won't think I'm retarded," nursing supervision would review the documentation in the record.

When the physician was asked why the issue of mental retardation was considered to be a breathing issue, he explained that the patient must have the ability to comprehend what to do with the type of equipment that would have been used. Her lungs would have been restricted and she would have had to cough when needed. There was the danger of carbon dioxide narcosis. He also explained that this hospital would be his first pick regarding treatment for himself and his family.

When asked how the hospital defines appropriate physician/patient/guardian interactions, the response was that the guardian is like a parent. When asked what the protocol is for preventing infection after surgery such as a hysterectomy, the response was they look for signs of infection, usually as part of the history and physical; the subject presents signs of fever when there is an infection. Medical staff monitor the patient's blood pressure, lungs, heart and extremities to see if they are back to normal. Any temperature of 101 or over is a concern. The patient's white count is assessed. Any ICU nurse should be able to assess. The resident was given clear liquids.

The HRA reviewed the following Decatur Memorial Hospital Policies:

- *Visits to patients (04/01)*
- *The policy for ordering meals (08/09)*
- *Our Promise - A Patient's Bill of Rights and Responsibilities (no date)*
- *Complaint and grievance policy. (11/00)*
- *DMH Website (includes policy for new employees regarding HIPPA, the da Vinci Surgical System, DMH Cancer Care Institute and Nursing practices)*
- Infection Control Data-Healthcare Acquired Urinary Tract Infections.

Records

The following is a timeline based on documentation in the record of care received by the patient that would apply to the allegations:

4/20/09 3:09 - The patient, 66 year old female was transferred and admitted to Decatur Memorial for continued evaluation of the diarrhea, abdominal pain and pelvic masses.

Three physicians reviewed her charts, labs and tests.

The diagnoses as listed on history and physical included mental retardation, chronic scoliosis, coronary artery disease with previous myocardial infarction and previous tent placement in 2002 and ischemic cardiomyopathy with an ejection fraction of 35-40%. The patient recently had intermittent abdominal symptoms; colitis, infectious with prominent lymph nodes, distended gall bladder, and abnormal urinary bladder were noted along with a mass-like lesion in the left-lower chest which would be consistent with metastic disease or malignancy. She was to be seen by general surgery, urology, and gynecology physicians. Stool samples were to be collected for a culture. Her history included coronary artery disease, congestive heart failure, ischemic

cardiaomyopothy, severe developmental delay, cerebral palsy, previous left eye blindness due to hemorrhage in the eye, hyperlipidemia, thrombocytopenia and history of left lung nodules as seen on CT-scan and which may have been seen in the past.
7:00 pm - The record documented that patient's needs were described as mental retardation and the patient was able to converse somewhat.
8:19 pm - It was documented in the patient's chart that this patient had a severe developmental delay. The liquid diet was discontinued and the patient had been prescribed a low fiber diet. Per notes, no tray was delivered.
10:05 pm - A charting note stated that 25% of the patient's meal was taken independently.
10:21 - A charting note by the nurse stated "Please put patient on my list!"
4/21/09 8:58 am - Charting notes stated that the patient is mentally retarded.
CT scans were completed
11:35 am - A consult with the physician was completed.
2:46 pm - The dietician assessment documented the patient weighed 57 kg (125.66 pounds.), that protein needs to be 20% of calories, caloric intake should be 1489-1770 and fluid intake should be 74-89 grams per day. Increased nutrient needs related to protein, as evidenced by labs and due to colitis and diarrhea, were noted although diarrhea had improved at this time. Inadequate oral food/ beverage intake related to illness as evidenced by recorded intakes was noted as well as a recommendation that the patient would benefit from a nutritional supplement on trays. The intervention was to include Ensure on dietary trays.

Notes from the state guardian's records:

6:00 pm - When her state guardian went to visit the patient on this day she documented: "That a food tray was in the patient's room on a table. The patient was hungry and thirsty. The staff from dietary called the patient's room to ask what the patient wanted for dinner. The guardian explained to them that the patient's food was already there. The dietary staff makes the comment: 'My God her lunch tray is still there.' The guardian touched the food and it was cold to the touch. Dinner and beverages were then ordered with guardian's assistance."

Hospital notes continued:

11:05 pm - It was documented in the chart that the guardian discussed miscellaneous problems and patient needs with the nurse.
4/22/09 - It is documented that the patient is "mentally disabled."
10:30 am A charting note stated that 100% of meal taken; at 1:27, 50% of meal taken. There was no documentation of dinner taken.
4/23/09 - There was no documentation of any meals or fluids taken.
4/24/09 9:37 - A charting note documented that only 10% of the meal was eaten.

Documentation from the next hospitalization starting on 7/20/09:

7/20/09 9:35 - The guardian was with the patient and completed the consent for surgery for a hysterectomy with the nurse.
11:47 am - The procedure was started.
1:29 pm - The surgery was completed (hysterectomy to diagnose the pelvic mass) and the patient was in recovery and in excellent condition. No evidence of malignancy was seen.
2:30 pm - It was documented that no assistive breathing needed. It was documented that the patient was instructed to cough and make deep breathing sounds. The caregiver was unsure if the patient understood.

4:10 pm - Per the physician, the patient was placed on 100 % oxygen with mask. Her blood gas was noted to have a carbon dioxide (CO_2) of 92. "Narcosis, a condition of confusion, tremors, convulsions, and possible coma that may occur if blood levels of carbon dioxide increase to 70 mm Hg or higher. Individuals with chronic obstructive pulmonary disease can have CO_2 narcosis without these symptoms because they develop a tolerance to elevated CO_2. When ventilation is sufficient to maintain a normal oxygen partial pressure in the arteries, the carbon dioxide partial pressure is generally near 40 mm Hg." The patient was given a dose of Narcan in which her CO_2 did get better at 65. The patient's pain pump was discontinued and she was admitted to ICU for close evaluation. Physicians were consulted to further evaluate her underlying medical problems and to evaluate for hypoxemia and hyercapnia because of chronic respiratory failure.
10:00 pm - The physician provided a consultation to the guardian and patient's nurse from the group home.
7/20/09 - The surgical path report documented that there was no invasive squamous cell carcinoma seen in the uterine cervix. No evidence of malignancy was seen in the ovarian tissue.
7/22/09 4:22 pm - The patient was up in the chair for approximately 30 minutes this afternoon It was documented that the patient was transferred with 2 staff and tolerated being in the chair well.
8:00 pm - The patient was in chair for about an hour this evening, in presence of caregiver and tolerated it well. The call light was on and the patient was checked. The rails were put up and the bed was low.
7/27/09 - A complete blood count (CBC) was completed. There was no evidence of an infection and her temperature was in the normal range.
7/28/09 4:55 am - The patient was incontinent. It was documented that she had a large amount of strong smelling urine.
7/29/09 - Per physicians progress notes, vitals were normal and it was okay to discharge to nursing home.
12:44 pm - The patient was discharged to a skilled nursing home. The discharge diagnosis was adnexal mass and acute respiratory failure. Rehabilitation services were ordered as well as physical therapy and an occupational therapy evaluation. Oxygen therapy ordered using a Bipap machine.

Documentation from the next hospitalization starting on 8/28/09
Emergency medical services notes documented that patient was brought to the emergency room on 8/28/09 - A subsequent hospitalization for complications such as vaginal bleeding that her physician could not control and the main complaint being a UTI.
8/29/09 3:00 pm - A charting note documented that the patient was resting in her bed and stated she had not eaten breakfast. The patient stated she wanted something to eat. The staff went through menu and called for a sandwich and iced tea.

SUMMARY

Complaint #1. Care is inadequate in that a patient contracted an infection while receiving treatment in the hospital. The infection was not addressed by hospital staff.

On 7/21/09 the nursing notes stated that the patient had several female visitors in her room all morning constantly out at desk asking when the lung physician was going to be there, along with other requests regarding patient care. The two women visitors were the patient's state

guardian, which was her substitute decision maker and an LPN who cared for the patient as a previous caregiver. They were both there to advocate on the patient's behalf, because of her disability and her current medical condition. In the *Our Promise - A Patient's Bill of Rights and Responsibilities* it states: "We are the doctors, nurses and staff of Decatur Memorial Hospital. These are our promises to you. We will tell you the truth. We will listen to you. You are part of our medical team. We want you to help decide the best ways to take care of you. We want you to help us with your plan of care. You may talk freely with your healthcare team. What you say will not be told to others unless it is important to your care and safety. It is okay to tell us what you do or do not want. To help us keep our promises to you and to help us with your care, PLEASE be honest with us about the following:
Your health and what it was like before now.
Any changes you notice about how you are feeling.
Any medications you take.
Your family's needs or worries.
Any religious, cultural or special physical needs.
Tell us your ideas about how we care for you.
Follow the directions of your doctors, nurses and other persons taking care of you.
Let us know when you can't follow our directions…."

Since the guardian was the substitute decision maker for this patient, it was the guardian's duty and responsibility to talk freely with the patient's caregivers which she attempted to do. Per the nursing notes, the guardian's role may have not been as well received as the patient's Bill of Rights says it would be. The guardian needed to obtain enough information to make informed decisions for the patient. The guardian asking to see a specialist to assess her ward and making other requests to meet the ward's needs should be encouraged.

The HRA was told that there is one nurse for every two patients for staffing in the ICU and normally staff are in the room checking on the patient. The majority of staff are RNs. There would also be a unit secretary, respiratory therapist, case managers and physicians coming in and out of the unit. It would be extremely unusual to not have someone in the unit. All ICU units are visible from the nurse's stations. There is nurse-to-nurse hand off once an hour. They rotate between the nursing assistant and the registered nurses. Some units have more frequent rotations. Documentation in the record noted that as part of daily bathing for the patient a back rub was provided which would have been very beneficial to the care of the patient. Pursuant to the Hospital Licensing Act, (210 ILCS 85/10.10.(2)) regarding nurse staffing by patient acuity "Evidence-based studies have shown that the basic principles of staffing in the acute care setting should be based on the complexity of patients' care needs aligned with available nursing skills to promote quality patient care consistent with professional nursing standards. In section (c) of the act it states that there should be a written staffing plan….Every hospital shall implement a written hospital-wide staffing plan, recommended by a nursing care committee or committees, that provides for minimum direct care professional registered nurse-to-patient staffing needs for each inpatient care unit. The written hospital-wide staffing plan shall include, but need not be limited to, the following considerations: (A) The complexity of complete care…."

Per DMH's website: "Central Illinois Surgery Center of Decatur Memorial Hospital offers a pristine environment and boasts an extremely low infection rate. Equipped with three state-of-the-art surgical suites, Central Illinois Surgery Center of Decatur Memorial Hospital

offers all private rooms with televisions and a comfortable waiting area." Per discussion with staff and review of the record, several tests were given to the patient and she had a normal white blood count on 7/27/09 after a complete blood count (CBC) was completed. There was no evidence that there was a temp of 101. On 7/29/09 her vitals were normal. However, there was documentation on 7/28/09 that the patient was incontinent and she had a large amount of strong smelling urine. One of the signs of a UTI is strong smelling urine per the Mayo Clinic website: http://www.mayoclinic.com/health/urinary-tract-infection/ds00286/dsection=symptoms. On 7/29/09, upon admission to the nursing home and immediately after discharge from the hospital, the individual was tested positively for a UTI.

On 7/22/09 at 4:22 pm the patient was up in the chair for approximately 30 minutes and the patient was transferred with 2 staff assisting; she tolerated being in the chair well. Then later it was documented at 8:00 pm the patient was in chair for about an hour. The call light was on and the patient was checked. The rails were put up and the bed was low. Unlike the documentation at 4:22 it does not say how the patient was transferred; this allegedly was the same time that the guardian and another visitor asked nursing to transfer the patient and the two staff had told the visitors that they could not do it because they were both pregnant. At the hospital site visit the HRA was told that there should have been staff available to provide lifting, to patients needing lifting, and that there were all sorts of equipment to move the patient, including a complete lift assist to the patient to sit, stand, and transfer. Staff should have been available to help move the patients. *DMH Website on Policy Regarding Patient Safety* states: "Utilize patient lifts….only use with a staff member who has had specific training in the use of the lift. Prevent falls by identifying patients who are at high risk and take extra precautions. The Fall Risk Assessment Protocol is located in our computerized documentation system…." It further states that "communication is the key for success for our patient's well being and continuity of care. Make sure to communicate any pertinent information to the nurse in charge of the patient's care. Most importantly if you are not sure or don't know ASK, anyone of our staff members will be happy to help…."

Pursuant to the (77 Ill. Admin. Code 250.1070 b), it states that "The hospital shall provide basic and effective care to each patient." The Hospital Licensing Act (210 ILCS 85/6.25) section regarding safe patient handling states that, "A hospital must adopt and ensure implementation of a policy to identify, assess, and develop strategies to control risk of injury to patients and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a patient. This includes procedures for a nurse to refuse to perform or be involved in patient handling or movement that the nurse in good faith believes will expose a patient or nurse or other health care worker to an unacceptable risk of injury. Section (9) states this policy should foster and maintain patient safety, dignity, self-determination, and choice, including the following policies, strategies, and procedures: (C) the right of a competent patient, or guardian of a patient adjudicated incompetent, to choose among the range of transfer and lift options…."

The HRA reviewed the *DMH Nursing Philosophy* from DMH's website and it states: "Nursing Practice at Decatur Memorial Hospital encompasses a wide variety of specialty practice areas from outpatient ambulatory care to advanced practice anesthesia. In all of these areas, we implement a professional practice model that emphasizes the autonomy and accountability of individual nurses and groups of nurses as they design and deliver care for their

diverse patient populations. Nursing leaders are expected to be transformational in their approach to nursing practice, leading us toward innovative solutions to meet the demands of the future. We do this through a council structure at both the hospital-wide level and department level where all practicing nurses have the opportunity and accountability to design and improve the practice of nursing in their respective settings. These councils, along with their nursing leaders, focus on measurable positive outcomes in the delivery of nursing care, continually evaluating evidence to design innovative processes for care improvement. We deliver nursing care within a patient care framework developed by nurses across the practice spectrum that places caring relationships with our patients and families as the key driver for innovation and excellence. Each practice specialty is responsible for designing a care delivery model which fits this framework and matches patients' needs synergistically with nurses who have the appropriate skills, knowledge and experience to address those needs. These staffing models are evaluated regularly by practicing nurses and leaders to continuously improve our effectiveness in meeting patients' needs and in establishing a positive work environment for nursing practice. "

There was not enough evidence in the record to determine if safe patient handling was/or was not provided per the allegation. There is policy to support appropriate safe handling procedures. Regarding the issue of not testing the patient for a UTI or providing treatment there was evidence the patient was tested two days before being released from the hospital to the nursing home. The patient did return on 8/28/09 because of vaginal bleeding and a UTI. There does appear to be some frustration in the documentation about the guardian out at the front desk asking for some assistance, but there is not enough evidence that adequate care was not provided. Based on the evidence the HRA **does not substantiate Complaint #1. Care is inadequate in that a patient contracted an infection while receiving treatment in the hospital. The infection was not addressed by hospital staff.**

The HRA does take this opportunity to make the following suggestions:

1. Involve the guardian as part of the treatment team. Provide staff training that the questions and concern from a guardian are not impositions, but guardians are the court-appointed substitute decision-makers for their wards, who must make informed decisions before they can provide consent to treatment. Unlike a parent they are not only trying to determine what is best for the ward, but what are the ward's wishes if that individual were fully informed of their choices and could make that determination for themselves. Involving the guardian usually makes providing treatment easier for staff.

2. Train staff that guardian requests such as this guardian's request for UTI testing is the same as if the patient themselves had requested this testing.

3. The HRA could not substantiate that no hospital staff were available to provide safe transfer for the patient, but the HRA would again suggest that the staff be trained to request help from appropriate resources if an individual needs to be transferred and if that staff person is unable to do so.

Complaint #2. Hospital staff and physician did not interact with the patient appropriately regarding her disability.

Pursuant to the Mental Health Code, in section **5/2-100 regarding Deprivation of rights, benefits, privileges or services** "(a) No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law…." The physician explained to the HRA that you must have the cognitive ability to comprehend how to participate physically with the type of equipment that would have been used without the ventilator. Hospital management explained that staff should have been able to meet any accommodations made for individuals with disabilities regardless treatment by caregivers. Regarding the allegation of the worker who made the comment about "I don't want them to think I am retarded" the HRA cannot determine whether this comment was made by a staff person based on the record and will not substantiate a complaint based on an allegation without hard evidence. There is the documentation on 7/21/09, "That the patient has several women visitors in room all morning…constantly out at desk asking when lung physician is going to be here along with other requests regarding patient care." Again there is the issue of staff not recognizing that a guardian is the substitute decision-maker for the individual and must be informed and involved in the patient's care.

Pursuant to (77 Ill. Admin. Code 250.260) regarding patients' rights it states that "hospitals shall have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional, and attitudinal health of the patient, patients' families and hospital personnel…." DMH does have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional, and attitudinal health of the patient, patients' families and hospital personnel in *Our Promise - A Patient's Bill of Rights and Responsibilities* and in related policies. The HRA did note in the records that this patient was referred to having a diagnosis of mental retardation, and documentation in the record by staff refer to the patient as MR, has a severe developmental delay, is mentally challenged or is mentally disabled. Some of these terms are somewhat outdated and can be offensive to those with disabilities. There was not enough evidence in the record to determine if hospital staff did/or did not interact with the patient appropriately regarding her disability. The HRA **cannot substantiate Complaint #2. Hospital staff and physician did not interact with the patient appropriately regarding her disability.**

The HRA does take this opportunity to make the following suggestion:

1. Provide staff training on courteous treatment of individuals with disabilities and their guardians, families and caregivers. Individuals with disabilities deserve the same sound treatment as anyone else. Mental Retardation may be a term used by a physician when he provides a diagnosis; however, staff providing care should be trained to have some sensitivity to the patients they are serving. Staff need to know that the word "retarded" is not appropriate to use in any circumstances, but especially in serving people with disabilities.

Complaint #3. Treatment may not have been appropriate for the individual's condition.

Regarding the Medical Patient Right Act in (410 ILCS 50/3), "The following rights are hereby established: (a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law…." Per the record on 7/20/09 at 9:35 the guardian is with the patient and completed the consent for surgery for a hysterectomy with the nurse. Per the record at 11:47 am the procedure was started. At 1:29 pm the surgery was completed (hysterectomy to diagnose the pelvic mass), the patient was in recovery in excellent condition. At 2:30 pm no assistive breathing was needed. It was documented that the patient was instructed to cough and make deep breathing sounds. The caregiver was unsure if the patient understood. At 4:10 pm per physician the patient was placed on 100 % oxygen with mask. Her blood gas was noted to have a CO_2 of 92. The patient was given a dose of Narcan and her CO_2 level improved. The patient's pain pump was discontinued. The patient was admitted to ICU for close evaluation. Physicians were consulted to further evaluate her underlying medical problems and to evaluate for hypoxemia and hyercapnia because of chronic respiratory failure.

At 10:00 pm the physician provided a consultation to the guardian and patient's nurse from the group home. The discharge diagnosis was adnexal mass and acute respiratory failure. Rehabilitation services were ordered as well as physical therapy and an occupational therapy evaluation. Oxygen therapy ordered was Bipap machine. The patient was in the hospital until 7/29/09. AT 12:44 pm the patient was discharged to a skilled nursing home.

The evidence showed the guardian discussed the option of surgery with the individual before the surgery was agreed to. The surgery was completed with the guardian's consent. The record also showed that there was serious concern over whether this individual had cancer. It was not expected for this individual to have respiratory failure and carbon dioxide narcosis. The surgery was completed by using the minimally invasive procedure of the da Vinci machine. Per the DMH Website: "In September 2011, Decatur Memorial Hospital upgraded this robotic-assisted surgical system to the new da Vinci® Si™ Surgical System third generation technology. Through the utilization of the da Vinci® Si™ Surgical System the DMH Center for Minimally Invasive Surgery provides a comprehensive offering of surgical advancements…. The DMH Cancer Care Institute is accredited by the American College of Surgeons Commission on Cancer and affiliated with the Association of Community Cancer Centers…." The individual did struggle with the effects of the surgery, but per the record there may have been no other way to ascertain the suspicious mass that could have been cancer. The least invasive form of surgery was used. Based on the evidence in the record including consent from the guardian the HRA **does not substantiate Complaint #3. Treatment may not have been appropriate for the individual's condition.**

Complaint # 4. A patient did not receive adequate hydration and nutrition.

Per charting by staff it was clearly documented that this individual had multiple disabilities, including a cognitive disorder. It was documented by the guardian at the hospital on 4/29/09 that this patient still had a cold food tray from lunch at 6:00 pm. The dietary staff were checking, at this time, for the patient's dinner needs. The guardian assisted the patient in

obtaining adequate nutrition. At a later hospitalization on 8/29/09 at 3:00 pm the patient stated she had not eaten breakfast and staff assisted the patient in obtaining food at that time. It is reasonable to assume that most patients would have had breakfast and lunch by 3:00 pm. At the interview with DMH staff the HRA was told that the rounding schedule of nursing should have taken care of the issue of inadequate nutrition and hydration. Per the policy of *DMH room service-meal ordering* 08/09 page 4, it states: "Patient having difficulty ordering: Tell the patient you will have someone from Food & Nutrition Services come to their room to provide assistance. More than one meal may be ordered at this time. When the Food & Nutrition Services staff visits the patient, they will evaluate the patient to determine if the Room Service Participation level should be changed and will coordinate any such change with nursing staff…."

In the section regarding if the patient or representative does not call to order meals it states: "If a patient is participating in room service and no meal order is called in for the patient for a specific meal by a given time, this will become apparent when the Missed Meal Report is ran. This Missed Meal Report will be run @ 8:30 am, 12:30 pm and 6:00 pm. The Room Service Operator will call the patient to investigate. If no meal order is called in for a patient for two consecutive meals, (one meal for patients on Consistent Carbohydrate diets), the Room Service Operator will notify the Clinical Dietitians for appropriate action. The Clinical Dietitians will contact the patient, Clinical Services and or the nursing staff to investigate…."

On another attachment on the *DMH room service-meal ordering* it also instructs: "to identify patients that have not ordered a meal and place a call to them. If the patient has missed 2 meals, you will need to inform the patient's nurse of the missed meals." It would appear that on 4/21/09 the missed meal report process actually worked, because a staff person called the patient's room to make sure the patient did not miss a meal. On 4/23/09 there was no documentation of any meals or fluids taken after she had been put on a special diet and needed to be monitored. On 8/29/09 it did not appear to work, but the patient was able to advocate for herself to ask for <u>breakfast at 3:00 pm</u> and a staff person helped the patient to obtain something to eat. The hospital licensing requirements (77 Ill. 250.1650) regarding the frequency of meals state: "To the extent medically possible, a minimum of three or their equivalent shall be served daily, at regular hours with no more than a 14 hour span between a substantial evening meal and breakfast. b) To the extent medically possible, bedtime nourishment shall be offered to all patients…." Under section 250.1670 regarding food preparation and service, it further states that "… Foods shall be attractively served at the proper temperatures and in a form to meet individual needs."

Pursuant to the Medical Patient Rights Act in (410 ILCS 50/3 a), "this patient deserves the same sound nursing and medical practices that anyone else would expect to receive…." Most patients do not receive breakfast at 3:00 pm, nor are they expected to eat a cold left over lunch at 6:00 pm. This individual was seen by numerous highly qualified physicians, however it appeared that her basic hydration and nutritional needs may not have always been met. There is also the concern that this individual might have eaten food that was unsafe because it had sat by her bedside for an undetermined time. Per the record there was documentation that the individual had a disability that limited her ability to use the call button. The HRA questions why a rounding schedule did not result in the removal of an uneaten, cold food tray or prompt

questions about the patient's food intake. Based on the evidence in the record **Complaint #4. A patient did not receive adequate hydration and nutrition is substantiated.**

The HRA makes the following recommendations:

1. To ensure compliance with hospital licensing requirements and hospital policies, staff should be trained to be more observant of individuals with disabilities and their nutritional needs. There should be a procedure in place to remove unsafe food that was hot, but then became cold.

2. Staff should check and make sure that an individual with a disability has actually been provided the appropriate meal for the shift they are working. Some patients are unable to advocate for themselves and are completely dependent upon the staff assuring they receive what they need.

Complaint #5. The patient's personal health information may not have been protected.

Per the record, the patient's information was kept private. Regarding the issue of no one checking to see who was coming in and out of the ICU unit, per the interview with Decatur Memorial staff, privacy was not found to be an issue due to the open access policy. This policy allows visitation from 8:00 am to 8:00 pm. Members of the immediate family may arrange to visit beyond regular hours. The HRA team did see on the unit, the elevator and at other locations in the hospital the posting of patient rights. Under visitation the rights statement documented: "More than two visitors at a time are discouraged from visiting. No visitor shall knowingly be admitted who has a known infectious disease, who recently recovered from such a disease, or who has recently had contact with such a disease. Exceptions will be based upon the patient's psychosocial and physiological needs determined by the nurse…." The Hospital Licensing Requirements in (77Ill. Admin. Code 250.250) regarding visiting rules states: "a) Each hospital shall establish, in the interest of the patient, policies regarding visitation on the various services and departments of the hospital. It is recommended that visitors be limited to two per patient at any one time. b) In times of increased incidence of communicable disease in the community, the hospital should consult with the local health officer regarding further restriction of visitors. c) No visitor shall knowingly be admitted who has a known infectious disease, who has recently recovered from such a disease, or who has recently had contact with such a disease…."

The Medical Patient Rights Act (410 ILCS 50/3 d) establishes "the right of each patient to privacy and confidentiality in health care. Each physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information may be disclosed to the patient, the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided, those parties directly involved with providing treatment to the patient or processing the payment for that treatment…."

Per DMH's policy for new employees regarding HIPPA (Health Insurance Portability and Accountability Act of 1996) it states that: "Decatur Memorial Hospital has pledged to our patients to keep their information confidential and to respect their privacy, there is zero tolerance for

a breach of confidentiality. Confidentiality means you may not disclose any information you have heard or read about a patient, this includes the patient's name or any identifying factors about that patient. Never discuss confidential information about patients and their families, unless it is with an authorized person in a private area. Privacy is also important with electronic transition, never copy part of a patient's chart and never download patient information (such as to a memory stick), and never put patient information into an email…." Based on the evidence of hospital policies which adhere to HIPPA, Public Health regulations and Medical Patient Rights Act and the record of the individual which appeared to have been kept private, the HRA **does not substantiate Compliant # 5. the patient's personal health information may not have been protected.**

The HRA would like to thank Decatur Memorial Hospital staff for their cooperation with this investigation.

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 10-060-9004

SERVICE PROVIDER: Decatur Memorial Hospital

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

✓ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

LINDA L. Fahey
NAME

V.P & Chief Nurse Executive
TITLE

8/15/2012
DATE

August 14, 2012

Mr. Larson Phillips, Chairperson
Regional Human Rights Authority
2125 South First St.
Champaign, IL 61820

Re: Human Rights Authority Case #10-060-9004

Dear Mr. Phillips:

We have received and reviewed the report of findings for the above-referenced investigation. It is apparent your organization performed a thorough and detailed investigation of the various complaints made in this case. The only complaint that was substantiated was #4, a patient did not receive adequate hydration and nutrition. The following processes were implemented shortly after your visit to our hospital to ensure that all of our patients' nutritional and hydration needs are met.

· Upon admission to the nursing unit, a nurse performs an initial assessment, part of which focuses on nutrition related questions including educating the patient on the room service process and assesses the patient's ability to participate. Notes are made for each patient for the following levels of participation:

1. Independent – Patients are capable of reading the menu and may call the Call Center to order their own meals.
2. Needs Assistant with Room Service – Patients are capable of making selections, but needs assistance with making selections or placing orders.
3. Temporarily Unable – Patient is temporarily not capable of participating even with assistance.
4. Unable to Participate in Room Service – Patient is not capable of participating even with assistance.

Patients noted as not capable of participating and who have a physician prescribed diet order will be provided a FNS approved meal.

Food Service will process a "Missed Meal Report" at the following times: 8:30 a.m. (Breakfast); 12 p.m. (Lunch); and 6 p.m. (Dinner) to identify patients who have not placed orders for meals. The Call Center will attempt to contact patients on this report via phone.

If no response, the Call Center will contact the nurse for assistance and/or determine if a Food Service Associate needs to visit the patient.

Based on specified criteria, the patient may also be visited by a Registered Dietician to develop a nutrition care plan to prevent malnutrition. Additionally, patients with sight or dexterity problems will be assisted by the Food Service Associate delivering the food. They will assist the patient with identifying the location of the food/utensils on their tray, as well as assist with opening milks, juices, condiment packets, etc. Patients requiring assistance eating will be identified as an "Assist Feed" in the Room Service Management System and the Food Service Associate delivering the tray will notify the nurse when the tray is delivered. Additionally, if a patient misses two (2) consecutive meals, a clinical dietician will be notified to assess the patient.

Decatur Memorial Hospital is committed to providing outstanding medical care and service to our patients. Thank you for helping us to improve our processes so that the needs of our patients are met.

Sincerely,

Michael J. Zia, M.D.
Vice President, Medical Affairs & Quality

Linda Fahey, R.N., M.S.N.
Vice President, Nursing

MJZ:bp/cg