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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9010
H. DOUGLAS SINGER MENTAL HEALTH CENTER

Case Summary: There were no substantiated findings. The facility is not required to respond.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the treatment of a recipient at H. Douglas Singer Mental Health Center, a state-run hospital in Rockford that has over seventy beds.

It was alleged that the facility did not provide a patient with adequate medical care for chest pains when the patient had to call 911 himself for help. Substantiated findings would violate rights protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Administrative Code for treatment and habilitation in Illinois Department of Human Services' facilities (59 Ill. Admin. Code 112) and Department policies.

The HRA visited Singer where the issue was discussed with facility representatives including a patient's physician. Program policies related to the complaint were reviewed as were sections of the adult patient's record with his authorization.

FINDINGS

The staff explained that Singer has a medical team available on a daily basis, reachable by pager after hours. Those physicians can provide care for chronic conditions like hypertension and diabetes, but not for critical conditions that require more intensive oversight. Physical exams are done soon after admission, typically within twenty-four hours, at which time any medical needs are identified and addressed within a medical treatment plan. The medical services team is involved whenever there is a medical complaint throughout a patient's stay. There is a nurse who monitors all medical care specifically, and attending or on-call psychiatrists may also be consulted.

When medical services are needed for patients whose conditions are stable, say with chronic obstructive pulmonary disease or diabetes, the program prefers that they follow up with their community physicians after discharge, which can be arranged as part of discharge planning. Singer contracts with a local hospital to provide medical services whenever there is an emergency or need for more immediate care; a second hospital's emergency department can be sought for emergencies as well. In those situations a transfer form is filled out and two staff members take the patient to the hospital. If two are not available, then an ambulance is called and at least one staff goes along. When the patient returns with orders, the orders are called in to medical services or the psychiatrist for "in-house" orders. Returning orders are considered recommendations by Singer physicians who must make final determinations on a course of treatment.

We were told there were two instances when this particular patient was taken to the hospital. In the first one he was experiencing pain at an evening hour when no medical services were on site. His blood pressure was elevated and a nurse consulted the on-call psychiatrist who ordered a stat dose of Clonidine and approved a hospital transfer. One staff accompanied him in an ambulance, and two brought him back in a car. A medical services physician and the attending psychiatrist were each notified, and the patient was cared for and routinely monitored. In the second one, they said it seemed the patient was not satisfied with his care as he wanted more pain medication, Vicodin. Although he was being monitored appropriately, he ended up calling the fire department and they arrived to take him to another hospital; the documentation about how the transfer played out is not the best, but the patient remained in good care at all times. The medical services physician who followed him at Singer added that nothing changed in the medical treatment plan as a result of the second hospital visit, other than a decrease in Warfarin, or Coumadin. He said the patient was diagnosed with chest wall pain at the hospital, which was not a critical matter, and that he was given the pain medication Toradol while there. The physician explained that Toradol is not to be given with Coumadin, and he was concerned about the patient's Coumadin levels. He said there was no issue regarding his history with pulmonary embolisms, that he regularly monitored his vitals and continued Vicodin as needed, which is demonstrated in the record.

A medical history and physical examination was completed on the patient's first day at Singer according to his chart. The report stated that the patient's chief complaint was back pain, a result of falling down some stairs a couple years ago, and he mentioned having a pulmonary embolism three years ago. He had been taking the pain medication Norco in addition to Warfarin. The examination noted nothing unusual about the patient's cardio-vascular or lung conditions. The physician's medical treatment plan was to monitor Coumadin levels given the embolism, and he ordered Warfarin daily for that and Hydrocodone and Acetaminophen every six hours for pain as needed. Medication administration records showed that these were given as ordered and that Hydrocodone was given frequently. The PRN, or as needed record stated that the patient requested the pain medicine for several different reasons, including knee pain, back pain, body pain and general pain.

Progress notes from two days later referenced the patient's complaints of chest pain at 10:50 p.m. A nurse wrote that she monitored his vitals, found his blood pressure to be high, and notified the on-call psychiatrist who ordered a medication. About thirty minutes later the patient reported worsening chest pain, and the nurse consulted the same psychiatrist who ordered an

immediate evaluation at a local emergency department. The record included referral and transfer forms and verification that he was taken there. Notes from the next morning stated that the emergency department had called in with the patient's status. He was diagnosed with chest wall pain; all lab results were within normal limits, vitals were good, and Singer was able to pick him up. He was offered more of his prescribed Hydrocodone on return, and there were no further complaints of pain until two days after that. A nursing entry at 2:00 p.m. noted the medical service physician's review of test results; he lowered the Warfarin dose and ordered another set of tests. At 7:30 p.m. the patient complained of chest discomfort. The nurse checked his vitals and notified the psychiatrist. He was given Hydrocodone although he said it was not helping. Almost an hour later the patient was quoted as saying he had called the fire department because he was angry about not being sent to the hospital. He was described as being calm as he complained about wanting something stronger. The next entry detailed his return from another hospital just after midnight. It stated that per the hospital, they had found nothing wrong but gave him some Toradol. He was described as being cheerful while standing at the nurses' station, and the information was referred to medical services. The rest of the record suggests that he had no further complaints; he continued to be monitored closely and was provided with prescribed care until his discharge three days later.

CONCLUSION

Singer policy on medical assessment states that all patients will undergo physical examinations within twenty-four hours of admission and that laboratory work-ups will be ordered as determined appropriate. Results and identified needs are to be documented in their records and discussed with them. The program's treatment planning policy calls for the medical history and physical examination to be integrated within the comprehensive plan.

Under Rule 112, physical examinations are done to promote the highest quality of humane care, treatment, health and safety. They are to include diagnoses, plans of medical treatment, recommendations for care, and treatment orders. On completion of the diagnostic exam, a treatment plan for any medical services shall be established as part of the recipient's individualized services plan (59 Ill. Admin. Code 112.30). The Mental Health Codes adds that every recipient is to be provided with adequate and humane care and services pursuant to their individual plans.

This patient's record included all of these requirements as well as documented evidence that an integrated medical plan and corresponding orders were followed to the letter. He was seen regularly by at least two physicians and monitored routinely by several registered nurses at Singer. The physicians found it necessary to send him to an emergency department the first time he reported pain but not the second, and when the patient decided to take matters into his own hands he was not prevented from going. Results from his second visit came up without new medical concerns, and Singer carried on with his care as planned, none of which was a violation of the patient's right to adequate and humane care. The complaint is not substantiated.