FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Adventist GlenOaks Medical Center
HRA #12-100-9018

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 Adventist GlenOaks Medical Center. In June 2012, the HRA notified GlenOaks of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation were as follows:

1. A consumer of mental health services was given a violent body cavity search at the time of admission.
2. The MD took the consumer off all her medical medications and would not contact her oncologist for her medical history; staff members ignored the consumer's requests to not use injections in her right arm due to swollen lymph nodes.
3. The consumer was not aware that she was taking psychotropic medications during the first few days of the hospitalization - she was told they were vitamins.
4. The consumer could not get any sleep because she was on suicide precaution and she was awakened every hour.
5. The consumer was denied requests for a laxative.
6. The consumer could not wear her sunglasses which she needed for a medical condition.
7. Male patients in the dayroom wore nothing under their hospital gowns which made her very uncomfortable.
8. The hospital will not provide the consumer with her medical records unless she paid $400 for a copying fee.

If found substantiated the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/).

Background

The 186-bed hospital, located in Glendale Heights, offers a full range of services, including emergency care, cardiology and cardiac catheterization, interventional radiology, behavioral health and obstetrics. The 61-bed behavioral health program serves adults and geriatric patients who are experiencing emotional, psychiatric, and behavioral or addiction disorders. The focus is to help individuals return to their optimal functioning and move forward with family life, work, school and other activities. The program's intent is to restore wellness, stability and independence.

Investigative Methodology

The HRA conducted an on-site visit in August 2012. While at Glen Oaks Medical Center, the HRA discussed the allegation with the facility's Quality Management Specialist, the Director of the Behavioral Health Program and a representative of Risk Management. The consumer whose rights were alleged to have been violated was interviewed by telephone. The HRA reviewed the consumer's clinical record with consent. The HRA acknowledges the full cooperation of agency personnel.

Allegation: A consumer of mental health services was given a violent body cavity search at the time of admission.

Findings

According to the clinical record, the consumer was admitted to the hospital on December 22, 2011 due to a change in her behavior that included hypomania, confusion, and insomnia.

Admitting documentation showed that the consumer received a skin integrity screening at the time of admission. The skin integrity check showed that scars and a bruise were observed. At the site visit it was stated that all consumers receive a skin integrity (body inspection) at the time of admission. The consumer is asked to get into a hospital gown; underclothing removal is optional. The consumer's body is inspected by a same gender staff member, and the staff member is looking for open wounds/abrasions, identifying marks, etc. It was stated that all consumers receive an explanation of the inspection and the body chart is reviewed with the consumer when observations are noted. It was stated that body cavity searches are not conducted at the time of admission. The only time that this type of inspection would be given is if the consumer reported inserting an object. A physician's order would then need to be obtained.

The hospital's "Patient Safety: Precautions & Monitoring on Behavioral Health Units" policy states that "admission precautions are in effect on all patients upon arrival on the units. During this period, until precaution orders are entered and a belonging/body search is completed, all patients are maintained within constant view of staff." When asked if the hospital has a policy specific to a body search, the above policy was referenced.

All of the consumers interviewed stated that the body inspections were conducted in their rooms and by a staff member of the same gender. Each consumer explained that hospital gowns are given and the assessment was conducted in a nonintrusive manner.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2, 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." Based on the information received, it is concluded that the consumer did not receive a body cavity search at the time of admission; the allegation is unsubstantiated.

Allegation: The MD took the consumer off all her medical medications and would not contact her oncologist for her medical history; staff members ignored the consumer's requests to not use injections in her right arm due to swollen lymph nodes.

Findings

Admission documents indicated the consumer's past medical history as: breast cancer, hypertension, hypothyroidism, mitral valve prolaspe, osteopenia, retinitis pigmentosa, supraventricular tachycardia. On the day of admission the Physician ordered Letrozole (used for the treatment of breast cancer), a thyroid hormone, and medication for high blood pressure per the

medical history. It was documented that the Letrozole medication was not available from the pharmacy. On December 23, 2011, the physician ordered that the consumer could use the Letrozole from home; family members were to bring in the medication. On December 25th progress notes documented that the medication was non-formulary. It was further documented that the consumer stated that she hoped that her family did not bring in the medication because she did not want to take it. On December 27th the medication was discontinued. The chart indicated that the recipient did not receive any intramuscular (IM) medication during her hospitalization.

At the site visit, it was stated that physicians do physician-to-physician reports, however there was no evidence in the chart that any contact was made with this consumer's oncologist. The consumer did receive medication for her thyroid, high blood pressure and also she took vitamins. The HRA was advised that upon receipt of this investigation, the Quality Management Specialist spoke with the consumer's medical attending physician, but he was unable to recall this consumer. And, after an internal review of this matter, it could not be determined why the medication was not available. It was explained that a formulary is a list of medicines. A hospital or clinic might have a formulary that comprises typical medications they use. A pharmacy insurance plan may also have a formulary, which lists preferred medicines. The major difference between formulary and non-formulary medications is the out-of-pocket expense. Each health insurance provider compiles and monitors the formulary for its insured individuals. Formulary lists can contain both brand-name and generic medications; non-formulary medications usually are only brand-name drugs.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

The recipient was not taken off all her medical medications during her stay; she received medication for her thyroid and hypertension. The physician would have needed consent from the consumer to contact her oncologist; there was nothing in the chart to show that this option had been discussed and/or that the physician refused to contact the oncologist; the allegation is unsubstantiated. Medication was ordered to treat her breast cancer; it was not available from the pharmacy and the physician ordered that she could use her own medication. The medication was not brought in by family members and the consumer stated that she would refuse the medication if it was brought to the hospital by family members. The consumer did not receive any IM medication during her hospitalization. Based on this information, the HRA does not substantiate the allegation that the MD took the consumer off all her medical medications and would not contact her oncologist for her medical history or that staff members ignored the consumer's requests to not use injections in her right arm due to swollen lymph nodes.

However, the HRA takes this opportunity to address the matter regarding non-formulary medication. The HRA believes that the hospital staff should have been more aggressive when it found that the medication was not available. There was no indication that an effort was made contact the consumer's oncologist for follow-up, to obtain an oncologist consultation, to see if a different medication on the formulary would have worked just as well, or that any efforts were made to get the medication from another source. And, best practice would seem to have the medication on hand to offer the consumer and then get the refusal, rather than (like in this case) take the consumer's word that the medication would be refused if and when it was brought from home.

Allegation: The consumer was not aware that she was taking psychotropic medications during the first few days of the hospitalization - she was told they were vitamins.

Findings

According to the clinical record, the consumer was informed of the side effects and of the risks and benefits of taking psychotropic medications. The record contained a signed consent for four psychotropic medications. According to the record, the recipient took these medications willingly for about four days; she then began to refuse the medications and the refusals were honored. The physician's order did show that she was also taking vitamins. The HRA noted that the consent form contained the statement showing that per the physician's medical opinion, the consumer had the capacity to make a reasoned decision about the medication. It was also noted that the consent did not have the date of the consumer's signature.

At the site visit staff said that consumers receive both verbal and written information on medication from both the physician and nursing personnel. The consumer is to sign a Patient Consent/Notification for Psychotropic Medications form that acknowledges that the consumer's physician or designee has advised the consumer in writing of the side effects, risks and benefits of the medication, as well as alternatives to the proposed medication. It was stated that should additional medication be needed after the initial consent is completed, the new medication is added to the existing consent and the consumer is required to sign the form for that medication.

Of the consumers interviewed, each consumer knew what medications they were taking and why the medication was ordered.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, "a recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. If the services include the administration of electroconvulsive therapy or 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. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment."

The recipient signed the consent for psychotropic medications and according to the clinical record, willingly took the medications. When she began to refuse these same medications, the refusals were honored and the medications were subsequently discontinued. Based on this information, it is concluded that rights were not violated. The allegation is unsubstantiated.

The HRA takes this opportunity to suggest that hospital personnel ensure that the medication consent form is signed and dated by the consumer.

Allegation: The consumer could not get any sleep because she was on suicide precaution and she was awakened every hour.

Findings

At the time of admission, the consumer was placed on close observation, meaning that she was observed by staff members every 15-minutes. The clinical record contained the completed 15-minute observation charts that were started on the day of admission. It is noted that the consumer

reported insomnia symptoms prior to her admission to the hospital. The record also showed that during the first few days of her hospitalization, she slept for only a few hours per night.

Hospital personnel stated that when a consumer is placed on close observation, staff members are to observe that person every 15 minutes. When a consumer is placed on a suicidal precaution, that consumer has a one-to-one staff member. It was also stated that during the sleeping hours, staff members must enter each consumer room and check on that consumer. Flashlights are used and the lights are not turned on - but, the consumer must be closely looked at to ensure safety.

The Precaution & Monitoring on Behavioral Health Units policy states that Close Observation Precautions are ordered for all patients admitted to a locked in-patient behavioral health unit.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2, 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." The consumer was not on suicide precaution; she was on close observation meaning staff members were checking her whereabouts every 15 minutes. During sleeping hours, the consumer was monitored for safety reasons. The record showed that the consumer slept only a few hours during her first few nights at the hospital; however the HRA is unable to establish that this was because of staff interference. The allegation is unsubstantiated.

Allegation: The consumer was denied requests for a laxative.

Findings

According to the clinical record, the consumer received a fleet enema on December 27th and Colace (as needed) was then ordered but was not administered. On the 28th the consumer reported that the enema had not been effective and she requested that prune juice be added with her meals.

At the site visit, hospital staff reiterated what the record documented, in that the consumer complained of constipation and an enema was given and additional medication was ordered.

When interviewing the consumers, it was asked if needs are readily met by staff members. Each consumer stated that staff member were accommodating and requests have been fulfilled in a timely manner.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2, 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." The record showed that staff members were aware of and addressed the consumer's needs. There was nothing to show that the consumer requested and was denied a laxative; the allegation is unsubstantiated.

Allegation: The consumer could not wear her sunglasses which she needed for a medical condition.

Findings

The clinical record showed that the consumer has Macular Degenerative Disease in her left eye. The personal possessions inventory listed glasses as an inventoried item. The inventory did not specify the type of glasses. The record does not document that the consumer asked for sunglasses during the hospitalization.

At the site visit, it was stated that some consumers do request sunglasses due to light sensitivity and this request would be granted. When touring the unit with a unit employee, the question about consumers wearing sunglasses was raised. This employee stated that sunglasses are

discouraged, but then said should a consumer complain of light sensitivity, sunglasses would be allowed.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." There was nothing to show that the consumer requested and was denied access to use sunglasses while in the hospital and staff members were attentive to light sensitivity. The allegation is unsubstantiated.

It is suggested that staff members be more descriptive with some inventoried items, such as glasses (reading, sunglasses, etc.).

Allegation: Male patients in the dayroom wore nothing under their hospital gowns which made her very uncomfortable.

Findings

Hospital personnel told the HRA that all consumers are encouraged to wear street clothes while out in the unit. The hospital does have clothes for consumer use should a consumer have limited clothing or if, for instance, the clothing is being washed. If a consumer is in a gown, two gowns are given to be worn front to back. And, underclothing is encouraged.

The record does not reflect that this consumer expressed this concern to staff members during the hospitalization. It was documented that the consumer often had to be redirected to put her gowns on appropriately while on the unit.

The males interviewed all were in street cloths, as were the ones the HRA observed on the unit. We noted a few females in gowns while on the unit and they all had pants on with the gowns.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2 2-102, "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan." The HRA does not dispute this consumer assertion that male patients in the dayroom wore nothing under their hospital gowns which made her uncomfortable. However, the information found does not support the claim; the allegation is unsubstantiated.

Allegation: The hospital will not provide the consumer with her medical records unless she paid $400 for a copying fee.

Findings

Hospital personnel stated that a review of documentation from the medical records department showed that the consumer requested her record on March 14, 2012. A copy of the request was included in the materials reviewed by the HRA. It was noted by medical records personnel that the consumer "did not check off any of the description of information on authorization form going to send back". According to hospital personnel, the authorization was sent back to the consumer with the request that she designate the information that she wanted from her chart on the authorization. It was offered that the consumer had not made any further requests for the record.

It was stated by hospital personnel that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes. However, due to the strict procedural and regulated steps involved in the release of information process, there are costs

associated and therefore a fee for the services is based on regulated rates (SB721 Public Act 92-228). The fee for her record would have been about $77.00.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act, a recipient of shall be entitled, upon request, to inspect and copy his/her record. This Act also states that "Assistance in interpreting the record may be provided without charge and shall be provided if the person inspecting the record is under 18 years of age. However, access may in no way be denied or limited if the person inspecting the record refuses the assistance. A reasonable fee may be charged for duplication of a record. However, when requested to do so in writing by any indigent recipient, the custodian of the records shall provide at no charge to the recipient…" The HRA found no evidence to support this claim; the allegation is unsubstantiated.