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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 13-080-9009
ROCKFORD MEMORIAL HOSPITAL

Case Summary: there were no substantiations. The Authority's findings follow.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of potential rights violations in the care provided to a patient on the behavioral health unit at Rockford Memorial Hospital. It was alleged that the patient was not examined by an appropriate physician for medical issues as requested, a social worker saw the patient fall in her room and refused to help her up and the patient was denied a chance to call her daughter about her concerns.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Part of the Rockford Health System, Rockford Memorial has nearly four hundred beds, twelve of which make up the adult psychiatric unit. We visited the hospital where the issues were discussed with representatives from legal and psychiatry. Related policies were reviewed as were sections of the patient's record with consent.

COMPLAINT SUMMARY

It was reported that the patient asked repeatedly to see a physician for preexisting medical issues with leg pain and numbness and her need to wear Ace bandages on them, but several days into her hospitalization she still had not been seen. At about the same time a social worker saw her fall in her room one day and would not help her up; she laid there for over an hour before a nurse helped her. Again she asked to see a physician and was told no. It was also said that a recreation therapist would not allow the patient to call her daughter about the incident.

FINDINGS

The staff we interviewed said that this patient was provided a medical consult just after her admission and the physician addressed her issues as presented. Patients typically wear slippers while in the hospital but in this case she was allowed to wear street shoes instead to help her walk more steadily. The physician ordered a Fentanyl patch which the patient wore on her shoulder for complaints of pain. She was assessed as a fall risk, which meant that she was identified with a bracelet, watched closely and checked every fifteen minutes, which is pretty general for patients. A nurse who spent a lot of time with her said she seemed to have no problems with walking and she was observed moving about the unit quite easily. The nurse said that the patient never asked to use a walker or wheelchair and never appeared to need them. Although it was not clear why she needed Ace bandages, they are not permitted for safety reasons and the staff would have gladly provided a walker or chair if she wanted. It was added that all patients' cases are discussed in daily meetings where ambulation issues would be raised but there was nothing notable about this patient. There was a fall incident later during her stay and she was seen by the same physician consult afterwards as she requested. The physician conducted an exam and ordered tests to rule out injuries. No injuries or decline in condition were reported.

Regarding the fall incident, a social worker explained that she saw the patient bump her left shoulder in her room's doorway, lean backwards and then slide down to the floor. She approached her and asked if she needed help but the patient would not respond to her. She asked if she was okay and again she would not answer. The social worker said that knowing she was a fall risk she did not want to move her and sought a nurse for help. The nurse told us that she and a psychiatrist observed the patient and together believed the "fall" was attention seeking. Since she refused their help she remained on the floor while the nurse watched her on the monitor. The patient was seen moving around on the floor without apparent distress until another nurse helped her up. They explained that an event occurrence form as part of a Risk Master process was completed. The form details the incident and ultimately goes to risk management who decides whether further review or action is warranted. They suggested that in this case there was no disposition from them. The program director offered her approval of how her staff handled the situation and was satisfied that they were neither abusive nor negligent.

On the question of whether the patient was allowed to call her daughter after the fall incident, a recreation therapist said that she did not recall the situation specifically and was unaware of the fall. Since the patient did not attend the fitness group that day she may have wanted to use the phone and would have likely been told to use it later as they are turned off during groups. She and the rest of the staff said they would not otherwise prohibit anyone from using the phone during off hours under special circumstances. The staff were certain that the patient reached her daughter later in the day as should be documented in the record.

According to the record, this patient was admitted at 5:44 p.m. on one day and seen for a medical consultation by 1:30 p.m. the next. Admission and assessment entries in the meantime showed that she had a history of chronic pain. She was described as having a staggering gait and was designated a fall risk because of that and the start of new medications which could increase risk. The medical consultation report stated that the patient complained of back pain as opposed to leg or knee pain, although it was noted that she had knee surgery in the past. She was previously on Fentanyl patches every three days but there was no indication from her pharmacy

review of needing or being prescribed Ace bandages in particular. The physician's impressions noted the back pain and continued following as needed along with the psychiatric staff. The physician's medication reconciliation orders included the continuation of Fentanyl patches every three days and Vicodin as needed. A psychiatrist wrote an order shortly thereafter allowing the patient to wear her own street shoes for gait stabilization. Several progress notes reflected the patient's requests for Ace wraps or bandages that she liked to use around her knees. In some instances a physician was alerted but he cited no necessary accommodations and in all instances it was explained to the patient that wraps and bandages cannot be used on the unit for safety reasons.

Records detailed the fall incident as well. The social worker wrote in her progress note about seven days into the admission that she observed the patient walking out of her room, bumping her left shoulder on the door frame then falling backwards into the door and sliding down to the floor on her butt. She informed the nurse and completed a Risk Master. The Event/Occurrence Executive Summary, or Risk Master, repeated the incident as described in the progress note and stated that it happened at 3:24 p.m. Another employee entered at 3:30 p.m. that it was a suspected intentional fall. The program director reviewed the incident also at 3:30 p.m. and a nurse listed no injuries at 4:27 p.m. A subsequent nursing note written about forty-five minutes after the fall stated that the patient remained on the floor. She said she could not get up although the nurse thought she could as she was moving all extremities and displayed "psychosomatic behavior". She coaxed the patient into pulling herself up while holding the bed, which she was able to do and then walked to the bathroom on her own. The patient complained of numbness in her leg; the nurse checked it out, found a slight bump but determined that she was able to bear weight, was able to ambulate and had a steady gait. The patient commented that she was a little anxious and the nurse continued to monitor. Fifteen-minute observation sheets reflected the same events and timeframes.

Progress notes also referenced a call from the patient's daughter about two hours after the incident. The daughter had concerns after hearing from her mother that they were not helping her or providing medical attention. The nurse reassured the daughter who was agreeable with how the situation was handled. The patient complained of numbness the next afternoon and asked for medical attention. The same consulting physician was notified.

As stated in the physician's consultation report, he completed an exam with the patient a few hours after being contacted. His impressions were that although she complained of sensory numbness of the arm and leg along with weakness she was unable to demonstrate it. He was unsure of whether she truly had a problem given her report of complex histories and current psychiatric illness. Because of various risk factors, he ordered a brain CT to rule out problems. Tests were unremarkable.

According to the discharge summary, the medical consult, an internist, saw the patient and managed her medical issues. She developed no medical complications during her stay.

CONCLUSION

Rockford Memorial policy on medical examinations for behavioral health patients states that a physical exam will be performed within twenty-four hours of admission. The physical exam includes medical and laboratory workup as appropriate. The medical physician performing the exam will take responsibility for managing any active medical problems that the psychiatric patient has while an inpatient on the psychiatric unit. The medical physician caring for a psychiatric patient may request consultations from other hospital medical staff as appropriate. (2000; 2060; #24).

Under the Mental Health Code, all recipients are to be provided with adequate and humane care and services pursuant to individual service plans. (405 ILCS 5/2-102a). All recipients must be free from neglect. (405 ILCS 5/2-112). Neglect means the failure to provide adequate medical or personal care or maintenance to a recipient, which results in physical or mental injury or the deterioration in a recipient's physical or mental condition. (405 ILCS 5/1-117.1). Facilities shall provide or arrange for comprehensive physical examinations within seventy-two hours of admission, excluding weekends and holidays. (405 ILCS 5/3-205.5).

In this case the patient was seen by an internist for potential medical issues and complaints within twenty-four hours of her admission. Medical workup and prescriptions were carried out as the physician deemed necessary, the physician followed the patient throughout her hospital stay, and there was no documented reference to any deterioration in the patient's physical condition upon discharge, all of which was called for in medical care policies, which are stricter than the Code's timeline requirement, and without neglecting the patient's medical needs as assessed. So, the complaint that the patient was not examined by an appropriate physician for medical issues as requested is <u>not substantiated</u>.

Hospital reporting policy addresses the management of sentinel events. Sentinel events are unexpected occurrences of death, serious physical or psychological injury or risk thereof. The employee who possesses the most information of any potential or actual event is expected to immediately communicate with the unit manager who in turn alerts risk management. They are also expected to complete a Risk Master Occurrence Report. (300; 320; #8). Patient/Visitor Incident Reporting (300; 320; #6), Suspected Child Abuse (300; 320; #11) and Suspected Abuse of Adults with Disabilities in Domestic Settings reporting policies (300; 320; #10) cite the same Risk Master process and/or contacts with appropriate law enforcements or licensing bodies. For suspected abuse of a patient in the hospital specifically, Rockford Memorial provided an algorithm that directs employees to notify various administrators and risk management accordingly and to document via the Risk Master process. Investigations and timely notifications to the Department of Public Health will be completed.

The Mental Health Code requires all facilities to provide humane care and prohibits the abuse and neglect of all recipients. (405 ILCS 5/2-102a and 112). Abuse is defined as any physical or mental injury or sexual abuse inflicted on a recipient other than by accidental means. (405 ILCS 5/1-101.1). Neglect means the failure to provide adequate medical or personal care or maintenance to a recipient, which results in physical or mental injury or the deterioration in a recipient's physical or mental condition. (405 ILCS 5/1-117.1).

By all indications from staff statements and their documentations, this patient's fall was not caused by them but rather herself. None of their intentional actions were abusive and there was no evidence of resulting physical or mental injury. Likewise with negligence since the patient was offered help several times, was approached by nurses and a physician after her fall and was visually monitored the entire time she chose to remain on the floor, which in total was about forty-five minutes. Further, we found no evidence that the social worker refused to help the patient up, she completed a Risk Master form, the unit manager reviewed the situation and a nurse examined the patient for any injuries, all required to ensure the patient's protection under hospital policies and the Code. The complaint that a social worker saw the patient fall and did not help her up is not substantiated as a rights violation.

An Access To Phones By Patients On The Inpatient Behavioral Medicine Unit policy states that public phones will be provided for outside calls when patients are not engaged in group sessions or other therapeutic activities. Specific times allowed for phone use may be posted. Telephone phone use may be restricted to protect from harm, harassment or intimidation.

This policy is in line with the Code that requires unimpeded, private and uncensored phone use to anyone of the patient's choice unless there is need to protect from the same. Reasonable times for phone use may be established. (405 ILCS 5/2-103).

Based on information from the record, this patient clearly was allowed to call her daughter after her fall as there are notations of the daughter following up with nursing staff about the incident within two hours of it happening. The complaint that the patient was denied a chance to call her daughter about her concerns is not substantiated.

SUGGESTIONS

Legal and psychiatry representatives told us that training on abuse occurs for all employees at the time of hiring. We point out the Hospital Licensing Act: "Every hospital shall ensure that all new and existing employees are trained in the detection and reporting of abuse of patients and retrained at least every 2 years thereafter." (210 ILCS 85/9.6 k). We encourage Rockford Memorial to set its abuse reporting algorithms into policy and include abuse detection and reporting training along with the mandate to do it every two years for all employees. While the Act addresses abuse and not neglect, the Mental Health Code does and we encourage the hospital to include neglect in the training, at least for behavioral health unit employees.

Policies on the suspected abuse of adults with disabilities in domestic settings, among the other abuse related policies, include a reporting system that leads to the Department of Human Services' Office of the Inspector General. We alert Rockford Memorial to the recent passing of the Adult Protective Services Act (eff. July 1, 2013), which shifts the reporting and investigatory authority for anyone over 18 years of age and older with disabilities in a domestic setting from that department to the Department on Aging. The DoA's Elder Abuse Program expansion can be reviewed at http://www.state.il.us/aging/1abuselegal/abuse.htm, the Act can be reviewed at 320

ILCS 20, and the Adult Protective Services Hotline can be reached at 1-866-800-1409, or 1-800-544-5304 (TTY). Policies should be revised to reflect the changes.