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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 14-030-9021
Vanguard MacNeal Hospital

Case summary: The HRA did not substantiate the complaint that the facility did not provide adequate and humane care.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Vanguard MacNeal Hospital (MacNeal). It was alleged that the facility did not follow Code procedures when a recipient did not receive adequate and humane care. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

MacNeal is a 427-bed community hospital located in Berwyn and is part of the Vanguard Health System. The hospital services an area of more than a million people and houses a 62- bed behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Vice-President of Psychiatry and Behavioral Health Services, the Director of Clinical Operations, the Nursing Director, the Behavioral Health Services Program Manager, the Quality Manager, and the Unit Registered Nurse. Relevant hospital policies were reviewed, and records were obtained with the written consent of the recipient.

COMPLAINT SUMMARY

A recipient had knee surgery at a Chicago area hospital and while she was there expressed her feelings of depression and hopelessness about returning home. She was then transferred to MacNeal Hospital, because doctors felt she could get psychiatric help for her feelings, and MacNeal would also have skilled nursing available to deal with her knee. Reportedly, while on the psychiatric unit staff did not have time to care for the recipient. She reportedly was pushed, hurried, and told by staff that the unit was understaffed and that they had other patients to attend to. When the recipient asked for pain medication, the staff allegedly waited two hours before giving the recipient her pain medication. Also, the recipient was allegedly left in the bathroom without staff to assist with hygiene, being told by staff, "That's not our job."

FINDINGS

The record shows that the recipient was admitted to the Behavioral Health Unit on 3/9/14. Her admission note states, "Pt had right knee arthroscopy Saturday. She went home and experienced much pain. Her pain meds were locked in a friend's car and they did not have the keys. She went to the ED at… because of her awful pain. Pt received pain meds intravenously and when she was being discharged she stated she was suicidal and then was transferred. Pt has a history of Bipolar since the age of 18. She at that time was receiving Lithium which did not agree with her. She has not taken any psych meds since then. Dr… notified of the admission- no psych meds ordered. Pt denies being suicidal. 'I just said that so they would treat my pain. Pt's husband with her. Dr… gave orders. Signed voluntary. Rights of Recipient reviewed and signed B and B [body and bruise] done. Pt has a flexible brace on her right knee. No drainage from incision site…" Progress Notes from the recipient's family session on 3/10/14 explain the recipient's admission to MacNeal, "… Pt recently had knee surgery and was in pain so she went to [an area hospital]. They refused to give her pain meds so the pt told them she was going to go home and kill herself…"

The record contains physician orders regarding the recipient's leg. It states, "Weight on leg as tolerated with brace. No bending of knee. May use walker- Pt eval for use of walker with brace. Tuesday take off ace bandage and gauze, leave steri strips on…"

The record shows that the recipient was evaluated for Fall Risk and received a score of 6 which placed her at high risk. High Risk Interventions enumerated on her chart include application of fall armband, not leaving the patient while on the toilet or commode, education of the patient and family regarding the risk of injury, and provision of self-care assistance. The recipient's Master Treatment Plan included the goal of ambulating and transferring with minimal assistance. The Treatment Plan Update included no bending of the right knee with the brace on, use of a walker (indicates that the patient refused), and use of a wheelchair for mobility.

Progress Notes written 3/09/14 state, "…Pt presented with depressed mood, flat affect, able to verbalize needs, tearful, complained of pain on right knee, received hydrocodone/acetaminophen 5/325 2 tabs at 4:45 p.m. reports pain to be sharp at 10/10 on the NS [pain scale], pt reports mild relief of pain, was at 5/10 on NS one hour after receiving pain medicine, assessed CMS [color, motion, sensation], pedal pulse +2 bilateral, can refill C350, able to turn and required assistance with ADL's redirectable, appetite is good…"

Progress Notes written 3/10/14 state, "…Pt has been out in the dayroom, tearful and presents with a depressed mood, and flat affect, verbalized fear of ambulating and complained of pain of 8/10 on the NS, right knee sharp pain and received acetaminophen 650 mg po at 6:28 p.m. with little relief, pt's pain was 6/10 on the NS an hour after receiving medicine, pt received hydrocodone/acetaminophen 5/325 2 tabs at 8:05 p.m. for pain, reported little relief 3/10 currently, patient remained tearful on the phone, reports that she's being forced to ambulate and focused on not being able to do things on her own- needs a lot of support."

Progress Notes from 3/12/14 indicate that at midnight, 1:00 a.m., 2:00 a.m., 3:00 a.m., 4:15 a.m the patient was offered help from staff to transfer from her wheelchair to her bed however she refused each time. The entry from 4:15 a.m. states, "Pt remains awake but drowsy. Pt still refusing transfer to her bed from her wheelchair despite much encouragement and assist of three staff to ensure safe transfer. 'I'm just afraid of the pain.' Pt currently rates pain at 8, prn of Norco 5/325 po given at 3:15 a.m…" The recipient was seen by the psychiatry resident the same day and the progress note from this meeting states, "Pt was seen and examined this morning. She expressed frustration at staff regarding her immobility due to her knee injury. Patient reports she slept poorly last night because she refused to let staff help her into bed and she slept in the wheelchair all night.…" The same day the progress notes state, "…The patient has been increasingly needy and reluctant in becoming self motivated around raising from her chair or getting up for breakfast or making an attempt to come for breakfast. She had visitors come and was informed of their arrival and had them wait 1 hour before she came out of her room. The pt had a nurse along with a sitter instruct her to raise with their assist and go to the bathroom. This process took nearly 45 mins…" Notes written that evening state, "…Pt…demanding and needy and needs much encouragement and assistance for pt to do her ADL's. Up to commode with 2 assist. Visible in the milieu. Social with peers. Inquiring about getting transferred to a rehab place says she feels she does not belong here and want to go 'someplace else'. Visited with family. Visit went well. Sitter at bedside. Bell at bedside. Ate 100% dinner. Med compliant. Taking Norco for pain. Will continue to monitor and encourage."

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed about the complaint. They indicated that the recipient had come to MacNeal as a transfer from another hospital emergency department. The recipient had undergone an outpatient knee procedure and returned to an emergency department to obtain pain medications. She had stated that her prescribed oral medications had been locked in her car. She was treated with pain medication. After consultation with her surgeon she was to be discharged to her home with oral pain medication and instructions not to bend or move her right leg. At the time of discharge, the recipient reported that she was diagnosed with Bipolar Disorder and had not taken her psychiatric medications for 8 years, had been feeling lonely for the past few months, was tearful, depressed and stated that if she was sent home she would commit suicide. The recipient was then medically cleared and transferred to MacNeal for psychiatric hospitalization. When the recipient arrived at MacNeal, she reported to the case manager that the emergency department had refused to give her pain medication and that is why she had told them she would commit suicide. She was then accepted for voluntary admission.

Hospital representatives stated that the recipient had outpatient knee surgery that would ordinarily mean that the patient would return home immediately afterwards with little or no pain medication. The recipient in this case, however, received pain medication very often and in large amounts that most patients would consider very strong. The recipient had requested so much medication that the staff considered that she may have been drug seeking. The staff indicated that the recipient was very demanding and required frequent intervention by staff. Additionally she had use of a bell situated near her bed to contact staff as well as a sitter and she was given 15-minute checks as well as being seen by a psychiatrist and medical attendant. Staff indicated that the staff on duty were very responsive to the recipient, however at times she required several

staff to assist her and other times she resisted staff help. The recipient's physician was notified while the recipient was in the emergency room. She was encouraged to ambulate and transfer from bed to a standing position with minimal assistance. Staff felt that the recipient was reluctant to self-motivate and was focused on remaining in the hospital and receiving medications.

STATUTORY BASIS

The Mental Health Code states, "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 (405 ILCS 5/2-102a)."

HOSPITAL POLICY

MacNeal provided hospital policy and procedure for Behavioral Health Interdisciplinary Assessment/Reassessment (BHS-102). It states:

"All patients admitted to inpatient Behavioral Health Services shall receive an individualized age-appropriate initial assessment of their physical, psychological, and social status within established timeframes. The patient/family/significant others are involved in the assessment process within the boundaries of confidentiality. Patient information is additionally gathered, as applicable, from other sources, including: previous care providers, referring emergency room or hospital, medical jewelry, and intake information.

The scope and intensity of any further assessments are based on the patient's diagnosis, condition, and identified special needs, care setting/goals, treatment and services, the patient's desire for care, and the patient's response to any previous care. Each patient is reassessed at regular intervals throughout the hospitalization and when significant change in condition or diagnosis occurs. This comprehensive assessment process ensures appropriate treatment focus and discharge planning.

A review of any original interdisciplinary assessments and updates shall be completed for any patient transferred from another MacNeal Health Network acute medical-surgical inpatient care area. A complete initial assessment must be done on admission. A new psychiatric Evaluation is performed every admission by the attending psychiatrist."

The Policy for Physical Status Monitoring (BHS-113) states, "Inpatient Behavioral Health Services shall regularly monitor and record the patient's physical status following the initial nursing admission assessment. Based on the patient's status and/or physician's order, increased frequency or other monitoring shall be done."

CONCLUSION

The clinical record and interview of hospital staff in this case does not support the complaint that the recipient did not receive adequate and humane treatment while hospitalized at MacNeal. The HRA is unable to substantiate the complaint.