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North Suburban Regional Human Rights Authority
Report of Findings
HRA #15-100-9004
Advocate Good Samaritan Hospital

Introduction

In October 2014, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Advocate Good Samaritan Hospital. A complaint was received that alleged that the hospital refused to treat a consumer for a head injury because his insurance had lapsed; the hospital tried to discharge the consumer without treatment; the hospital transferred the consumer to another hospital without notifying the family.

The rights of consumers are protected by the Federal Code of Regulations (42 CFR 482).

According to the Advocate Good Samaritan Hospital web-site, the hospital is a 333-bed hospital committed to providing clinically excellent, compassionate care. Good Samaritan Hospital features DuPage County's only Level I trauma center, a certified Level III neonatal intensive care unit and Magnet recognition for nursing excellence. A range of services are offered at the hospital, including cardiology, orthopedic surgery, general surgery, gastroenterology, stroke care, obstetrics and gynecology, low-dose diagnostic imaging, behavioral health services, and a comprehensive breast center. Good Samaritan Hospital is part of Advocate Health Care.

Methodology

To pursue this investigation, the HRA reviewed a consumer's clinical record with written consent. The HRA conducted a site visit in January 2015, at which time the allegation was discussed with the Director, Quality, Regulatory & Service; a Medical Social Worker, a Manager of Care Management, the Director of Health Information Management, and the Director of Behavioral Health. The HRA acknowledges the full cooperation of hospital personnel.

Findings

According to the clinical record, the 19-year old male presented to the hospital via ambulance on July 21, 2014 at about 11:30 p.m. The history and physical documented that the consumer has severe autism and is essentially nonverbal and noncommunicative. He lives with his grandmother who reported was his legal guardian. He was sent to the hospital due to increased agitation, "acting out", and it was reported that he had been hitting his head into the wall for the past few days. A physical examination was conducted that included vital signs and laboratory tests. The examination results showed that the consumer was alert and in no acute distress; his skin was warm, dry and without rash; his head was normocephalic, atraumatic; no tenderness was noted in his neck and he showed a normal active range of motion in the neck; his pupils were equal, round and reactive to light, extraocular movements were intact, normal conjunctiva; his oral mucosa was moist, with normal peripheral perfusion and his lungs were clear to auscultation, respirations were non-labored. He became agitated when the gastrointestinal examination was conducted and was noted as

soft and nontender; he showed spontaneous range of motion without any apparent extremity pain or tenderness; he was noted to be awake and alert, CN (Cranial Nerves) 2-12 grossly intact (function of the cranial nerves normal) grossly equal and normal movement of all extremities, speech was clear but very limited. The laboratory results were unremarkable. The consumer was medically cleared for a transfer.

At about 12:30 a.m. (July 22) it was documented that the consumer was being evaluated by the psychiatric intake worker. It was documented that the consumer would require psychiatric placement for increasing agitation, but that he could not be hospitalized at Good Samaritan because they did not have the appropriate facilities for patients with autism who have psychiatric needs. It was documented that a SASS (Screening, Assessment and Support Services) worker would be contacted for evaluation and assistance with placement. A few hours later, it was noted that the psychiatric intake worker determined that the consumer's Medicaid insurance status had ran out, and that therefore the SASS worker would not come to assess the consumer. It was later documented that the psychiatric worker had not had success in finding placement for the consumer. It was noted that because the consumer had remained calm during the ED (emergency Department) observation, the Intake Worker would request that the psychiatrist see the consumer later in the morning to determine if the consumer could be discharged back to the care of his grandmother.

The consumer was seen by the Psychiatrist that afternoon (about 3:00 p.m.); it was felt that he could be discharged home. At 4:00 p.m. it was documented that the grandmother was called several times about the discharge plans and several messages were left; the police were notified and an officer was to be sent to the home. The police reported back to the hospital that the grandmother did not answer the door and did not answer the telephone calls made by the police. The police noted that there was a car in the driveway. Documentation indicated that calls were made to the grandmother regularly for the next few hours and no contact was made.

At about 8:00 p.m. on the 22nd, the police contacted the hospital saying that they had spoken to the grandmother and they instructed her to come to the hospital to pick up her grandson. At 10 p.m., the Social Worker called the grandmother and made contact. The Social Worker documented that it was explained that the consumer was ready for discharge. The grandmother told the Social Worker that she (the grandmother) would go to the DHS (Department of Human Services) office the following morning to try to get the consumer's public aid reinstated. The grandmother believed that the consumer needed to be admitted but that he was not being admitted due to lack of funding. The Social Worker reiterated that the consumer was ready for discharge. The grandmother replied that she could not put her life or his life in danger, he was using his head as a bat, and that she had locked herself in a room when she called the police for help. The Social Worker then confirmed with the grandmother that pick-up would not be made; the grandmother replied that she would be at the DHS office in the morning, thanked the Social Worker and terminated the call. The Social Worker then contacted the Office of the Inspector General to file a report.

On the 23rd, documentation showed that the Social Worker spoke with SASS regarding screening the consumer for inpatient treatment as this was what the grandmother had requested. The following day, it was documented that the Social Worker had been working with the business office and the SASS care line to obtain the public aid number assigned to the consumer from the previous day. On the 25th, it was noted that the public aid had been reactivated. SASS had been contacted and they would evaluate the consumer for inpatient psychiatrist services within 24 hours. The next entry states that, *"Per SASS worker who spoke with the pt's grandmother, she stated she does NOT want pt to receive inpt. psych. tx. Stated that she only brought him to the hospital because she was concerned that he might have a concussion from banging his head on the walls, she is willing to take him home as long as he is medically cleared. Pt had not done any head banging while in the hospital, he will occasionally throw objects or pace in his room,*

chanting to himself, he refused his a.m. meds but did receive an IM Geodon is pm with encouragement, nursing contact grandmother to inform her that pt. may be dc'd from hospital now."

An RN then noted that the consumer had old markings to his hands, arms and legs and that the markings appeared to be cigarette burns. This was relayed to the Physician, the Care Manager, the Psychiatric liaison and the Social Worker. It was documented that "an agency" was contacted in regards to the safety concerns and findings.

It was documented that the grandmother was not able to be reached on 7/25 or 7/26/2014. When contact was made on the evening of the 26th, the grandmother stated that no calls had been made and that she had an attorney involved regarding the treatment that the consumer had been receiving at the hospital. Later this same evening, the consumer's caregiver called saying that the grandmother wanted to know if the consumer could be picked up on the 27th. The entry noted that the agency that had been notified about the markings would need to determine if the consumer could be discharged back to the grandmother. On the 27th the grandmother contacted the Social Worker about the consumer's discharge status. The Social Worker advised the Grandmother that she needed to speak to the RN and MD regarding the consumer's discharge. The grandmother stated that she had spoken to the SASS worker who told her that the consumer did not need behavioral health care. The grandmother stated that she feels that the hospital was holding the patient despite her wishes to now bring him home.

On the 28th, progress notes documented that the Social Worker met with the Case Manager, the Charge RN, a representative of PACT (a service coordination agency for people with developmental disabilities) and an OIG (Office of the Inspector General) worker. The discussion was about the ongoing issues with the consumer's behavior and the consumer's grandmother's behavior. At that time, it was determined that the consumer's grandmother would not be involved with the decision making for the consumer. It was documented that, according to the PACT worker, the consumer is currently his own guardian. The PACT worker reported that the grandmother had refused to obtain guardianship for him. The PACT worker stated that he will begin the guardianship process for the consumer, and that another PACT and SASS workers were working on finding emergency placement for the consumer.

On the 27th, progress notes document that the consumer had not slept in over 24 hours, he paces the room and that he is becoming harder to redirect. The consumer also became combative and hit and bit staff members. On the 30th, progress notes documented that the consumer was agitated, jumping, screaming, and banging his head. Public security was called to remain at his bedside and medication was given to help him gain control. Also on this date, the Physician documented that "per meeting with Office of Inspector General, state to take custody of patient; he will be placed in inpatient psychiatric facility until more long term placement available." At this time, the SASS worker evaluated the consumer and was attempting to locate inpatient psychiatric services; she had received denials from 12 hospitals. On the morning of the 31st, it was observed that the consumer was resting quietly in bed, no apparent discomfort, distress or agitation was noted. At about 3:30 p.m., it was documented that a hospital had accepted the consumer for inpatient psychiatric treatment

At the site visit, hospital personnel stated that no person is ever turned away or refused treatment due to lack of insurance. Hospital personnel stated that the consumer was examined upon arrival and was medically cleared. It was speculated that there was some confusion on the grandmother's part regarding the public aid in regards to the SASS assessment. It was stated that the hospital did not try to discharge the consumer without treatment – he was medically cleared and the hospital did not have the means to meet this consumer's behavioral needs. Regarding the allegation that the hospital transferred the consumer to another hospital without notifying the family, it was stated that it is standard practice that the family would be notified of any change in a patient's care.

The hospital provided a Transition of Care Report that showed that the Grandmother was the contact person-however the form did not specifically say that she had been contacted about the transfer.

The hospital's Discharge Planning policy states that its purpose is to describe the process of providing timely and appropriate discharge planning services for all patients and their families within the acute care setting. The policy goes on to state that discharge planning is developed using a multi-disciplinary approach. The patient/family/significant other is involved in discharge planning. The nursing and care management team reassess patient transition needs throughout the course of hospitalization through daily assessment. Communication to patient (and/or family) about transition plans takes place through daily rounding and phone communication when appropriate.

Conclusion

The Code of Federal Regulations Section 482.13 states that, "(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible." Section 482.43 states that "(b) *Standard: Discharge planning evaluation.* (1)The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician."

The HRA found nothing to support the claim that the hospital refused to treat a consumer for a head injury because his insurance had lapsed; the allegation is unsubstantiated. Similarly, nothing was found to support the claim that the hospital tried to discharge the consumer without treatment; the allegation is unsubstantiated. Nothing was found to show that the consumer's family member was contacted about the transfer. The hospital was making every effort to protect this patient from neglect; they were pursing the appropriate authorities to maintain his safety and they were initiating guardianship. Given the problems they had contacting the grandmother during the hospitalization and the problems they had finding a placement for this patient, it is concluded that the patient's rights were not violated when the family was not notified of the transfer. Nevertheless the hospital must document discharge notifications.