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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 17-050-9011
ABRAHAM LINCOLN MEMORIAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) conducted an investigation into the care of a patient with disabilities at Abraham Lincoln Memorial Hospital. The complaint is that the patient was not provided with adequate discharge planning, a potential violation of state Hospital Licensing Requirements (77 Ill. Admin. Code 250) and the Centers for Medicare/Medicaid, Conditions of Participation for Hospitals (42 CFR 482).

Located in the town of Lincoln, the twenty-five-bed hospital affiliates with Springfield's Memorial Health System. The matter was discussed with a nursing officer and a System attorney. Policies were reviewed, as were relevant sections of the patient's record with authorization.

COMPLAINT SUMMARY

The patient was involuntarily discharged from an area nursing home and abandoned at Lincoln Memorial's emergency department. She remained at the hospital some four months later where the complaint alleges the failure to ensure adequate discharge planning. Reportedly, the hospital insisted that the patient, who has a traumatic brain injury, be transferred to a psychiatric facility, and it provided no other options and rarely communicated with the guardian on anything related to discharge.

FINDINGS

The patient was never formally admitted having no medical need for hospitalization, according to Lincoln Memorial. Her nursing home left her at the emergency department and refused to take her back. She was cared for by the department staff as any traditional patient would be in the meantime, and was thoroughly evaluated for potential needs including mental

health, and it was determined that her presenting condition, behavioral in nature, was traumatic brain injury-related and not a mental illness. She was placed on the medical-surgical unit, having nowhere else to go. Although not an admitted patient, she was still provided an attending physician, a care plan and medications during her entire stay while there was no billing for services. The nursing officer explained that the patient was treated with as much care as would be for anyone else; she was provided transportation to outside appointments and was assigned a caseworker for discharge planning.

Regarding discharge planning, the issue within this case, Lincoln Memorial said they contacted the patient's guardian quite often with options for transfer but the guardian would never agree to the places offered, and contrary to the complaint, they were not insistent that she go to a mental health facility. They found that during most calls, the guardian drifted from talking about discharge preferring instead to focus on troubles with the previous nursing home. Numerous calls were made to other nursing homes and rehabilitation centers, well over one hundred. Information would also be faxed over but at several places they were told the guardian had already reached them and was unsatisfied. A developmental disabilities placement agency was also reached for potential placement and they were told the patient had a failed history in that setting. The agency later agreed to reopen the case, however. The staff told us they believed they provided more than adequate discharge planning and were certain the record would reveal supportive documentation.

Initial interview sheets completed by nursing at the patient's arrival on December 12, stated that the patient was not cooperative with most of the assessment. She was brought in from a nursing home, her discharge disposition was uncertain at that time and they would need to work on placement. A physician's report from the same time noted that the nursing home had presented involuntary discharge papers. The physician spoke with the patient's guardian who declined any form of psychiatric admission. A mental health evaluation was completed a few hours later and it was determined that her behaviors posed no significant dangers and were related rather to her traumatic brain injury; she was not a candidate for psychiatric admission.

Case management notes showed that contact was made with the discharging nursing home within the patient's first twenty-four hours there to explore the situation. Nursing staff confirmed that the home would not allow her return and they were immediately in telephone discussions with the guardian and an ombudsman to further assess the circumstances. Within the first forty-eight hours the hospital was in touch with an alternative provider to discuss placement opportunities. Over the next few days the hospital was in touch with eleven providers according to the documentation. Only one was a mental health facility within the health system, which had no available beds. Most declined admission while a few gave pending statuses. There were notations of having contacted or attempts at contacting the guardian to keep her apprised each day. There were several entries regarding contact with her in addition to more provider potentials over the next few weeks, and one, in-person meeting with the guardian to discuss continuing placement efforts. There were also several entries referencing visits from a number of provider agencies who met with the patient through discharge. Consistent contact or attempts at contact with the guardian is noted throughout. The patient was transferred to a group home on April 26.

We asked for verification of the exact number of placement options the hospital reached during the patient's time at the hospital and were given a list that contained the names and contact details for one hundred-thirty-seven facilities.

CONCLUSION

Hospital policies state that the discharge planning process involves expediting communication, coordination and collaboration between patient, family, hospital staff and the community to ensure continuing care. Coordination with community resources is based on identified patient needs, coordination with developmental disability screening agencies included.

Under Illinois' licensing requirements, hospitals must arrange discharges that are appropriate and based on a patient's needs and ensure that receiving facilities are capable of meeting them. (77 Ill. Admin. Code 250.240). CMS Rules call for the inclusion of patient representatives in care planning who have the right to make informed decisions. (42 CFR 482.13). Hospitals must identify patients at an early stage who are likely to suffer adverse consequences upon discharge if there is no adequate discharge planning, based on evaluation that is supervised by a registered nurse, social worker or other appropriately qualified person. As needed, family members or interested persons must be counseled to prepare them for post-hospital care. (42 CFR 482.43).

The complaint is that Lincoln Memorial failed to provide adequate discharge options for the patient and keep in contact with her guardian. The hospital evaluated the patient immediately and determined that she was more appropriate for a residential facility, and efforts to coordinate a transfer carried on from there through discharge. There was also evidence of guardian inclusion with considerable contact from the hospital to the extent the guardian would allow as required in policies and regulations. A violation is not substantiated.