FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #18-100-9001
Advocate Good Samaritan Hospital

Introduction

In August 2017, the North Suburban Regional Human Rights Authority (HRA) opened this investigation regarding Advocate Good Samaritan Hospital. A complaint was received that alleged that a patient receiving services in the behavioral health program did not have a treatment plan. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

According to the Advocate Good Samaritan Hospital web-site, the 333-bed hospital is committed to providing clinically excellent, compassionate care. The behavioral health program is a multidisciplinary team approach that offers assistance to patients with depression, schizophrenia, bipolar, anxiety, and other psychiatric diagnoses and dual diagnosis. Individualized programs focus on education, symptom management and coping skills. Levels of care include: the Inpatient Program that focuses on short-term hospital care for stabilization and crisis management; the Partial Hospital Program is a therapeutic, structured, daytime program as an alternative to inpatient care or a transition from inpatient treatment; and outpatient therapy is available on an individual or family basis. Good Samaritan Hospital is part of Advocate Health Care.

Methodology

To pursue this investigation, the HRA reviewed a patient's clinical record with written consent. The HRA conducted a site visit in October 2017, at which time the allegation was discussed with the Manager, Risk Management; the Director of Behavioral Health, Oncology and Ambulatory Services; the Director of Quality/Regulations; the Manager of Inpatient Behavioral Health Services; a Social Worker for the Behavioral Health Program; a Registered Nurse for the Behavioral Health Program, and the Assistant Nurse Manager.

Findings

The clinical record revealed data on an adult male college student transferred from another hospital's emergency department. He was diagnosed with schizoaffective disorder; he signed an application for voluntary admission on May 16, 2017 and was discharged on June 1, 2017.

According to chart documentation, on the day of admission the Physician assessed the patient and documented that the patient was not appropriate for outpatient treatment due to his increasing severity of psychiatric symptoms, the patient's noncompliance with medication regimen due to the severity of his psychiatric symptoms, his inadequate clinical response to psychotropic medications and the need to monitor the patient's clinical response to psychotropic medications. The chart included a Behavioral Health Patient History form that included information regarding the

patient's behavioral health history (chief complaint, recent changes in functional status, declaration for Mental Health Treatment, attempts to hurt yourself, etc.) and his social history (alcohol use, cultural/religious practices, exercise, home/environment, substance abuse, and tobacco use). The Physician documented the following initial treatment plan: "patient seen and evaluated with the nurse; patient admitted voluntarily for further stabilization; will start patient on Risperdal 1 mg. by mouth twice a day; patient will meet with the treatment team on the floor where the medications can be adjusted, titrated as needed, or changed; patient will be monitored for side effects from the medications; patient will attend groups on the floor; patient will receive psychotherapy on the floor; patient was educated about his mental illness, risks and benefits of the medications and side effects; PT/OT evaluation; Consults: medical doctor on consults; patient will meet with social worker for disposition planning". The chart contained about 40 pages of Power Plan/Interdisciplinary Plan of Care documents. Within these pages were five identified Problems: Transition Planning, Progressive Mobility, Behavioral Health, Risk of Suicide and Restraint Utilization Violent. Each identified problem contained a status, history, outcome, result and intervention. For example:

Plan: Transition Planning
Status: Discontinued
History: Suggested at 5/16/17
Accepted at 5/16/17
Initiated at 5/16/17
Discontinued at 6/1/17
Outcome: Patient/Family has the resources needed for safe transition to next level of care
Result: [staff members charted the results at least twice daily; below is an example of said charting]
Not ready for transition
Adequate for transition
Progressing toward transition
Intervention: Interdisciplinary Rounds/Discussion

The chart also contained Inpatient Multidisciplinary Staffings that showed the following treatment and interventions: Suicide Precautions, Falls Precautions, Medication Adjustment, Group Programming, Education Programming and Family Sessions. The chart documented that the patient received "orientation to hospital setting, orientation to unit, patient care conference, plan of care, standard precaution/cough etiquette."

At the site visit, hospital personnel explained that the behavioral health program has 36 beds for inpatient adult programming; 6 beds are used for those needing intensive services. The hospital does not have adolescent programming. The program averages 26 patients per day. Patients typically are admitted via the hospital's Emergency Department. Referrals are also made from other area hospitals and patients can be referred by their psychiatrists. Treatment planning meetings are held once per week; each patient will see his/her nurse and physician on a daily basis.

It was offered that at the time of admission, the patient identified in this case was distracted and uncommunicative. Often it would take him an unusual amount of time to complete simple tasks. The chart showed that he isolated during the hospitalization and did not consistently attend the therapies offered. The patient was noted to have poor eye contact, speech was underproductive, and he appeared to be internally preoccupied and paranoid. Hospital personnel stated that the patient's mother was very distraught throughout the patient's eight day stay. She was frustrated that the patient was not improving and she was tired of the hardship of the hour and a half daily commute from her home to the hospital to visit her son. She wanted the patient transferred to a hospital closer to her home. Staff members tried to get the patient admitted there, but that hospital

did not have any available beds. The patient was subsequently discharged home with his parents. Physician note documentation written on 5/19/17 showed that the Physician spoke to the mother who expressed dissatisfaction because the physician had not called her the first day of her son's hospitalization. The physician explained that he usually calls the second day and that he always has family meetings. The physician then documented that the mother was irritable and complained about the patient's lack of care, saying that the patient has wasted four days of being hospitalized.

The hospital's Interdisciplinary Plan of Care policy states that its purpose is to facilitate collaboration among interdisciplinary team members contributing to the patient plan of care with the goal of achieving optimal patient outcomes. The policy states that the RN coordinates the patient plan of care, initiates and discontinues the plan of care in collaboration with the interdisciplinary team, patient and family. Initiated plans of care address acute patient problems based on individual patient assessment which are preventing patients from transitioning to the next level of care.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 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."

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 3-205,"When any person is first presented for admission to a mental health facility under Chapter III of this Code, within 72 hours thereafter, excluding Saturdays, Sundays, and holidays, the facility shall provide or arrange for a comprehensive physical examination, mental examination, and social investigation of that person. The examinations and social investigation shall be used to determine whether some program other than hospitalization will meet the needs of the person, with preference being given to care or treatment that will enable the person to return to his or her own home or community."

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 3-209, "Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days."

The clinical chart showed that the patient receiving services in the behavioral health program had a treatment plan and that staff members were addressing the issues; the allegation is unsubstantiated.