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Egyptian Human Rights Authority
Report of Findings
Union County Hospital
HRA# 18-110-9009
March 14, 2019

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations in the care provided to a recipient at Union County Hospital (UCH) in Anna, IL. The specific allegations are as follows:

1. **Inadequate care and treatment of a patient.**
2. **A patient was discriminated against based on disability.**

If the allegations are substantiated, they would violate protections under: The Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.); the Medical Patient Rights Act (410 ILCS 50/3); and Hospital Regulations (77 IL ADC 250).

Union County Hospital emergency department (ED) has 6 beds to accommodate patients of all needs and the HRA was informed it is very common for the hospital ED to serve people with mental illness and developmental disabilities. The allegations were discussed with administrative staff at the hospital, family members and the Community Integrated Living Arrangement (CILA) home staff. Relevant policies were also reviewed as were sections of the recipient's records with authorization.

Complaint Summary

The allegations involve two different recipients. The complaint alleged that Union County Hospital provided inadequate care and treatment to recipient 1 by discharging her prematurely resulting in readmission the following day. The allegations also state that both recipients 1 and 2 were denied admission unless the CILA home provided a sitter to supervise the recipients during the entirety of the admission.

"Sitter" is defined in UCH policy as *a person assigned to assist in the monitoring of a patient whose condition warrants close supervision in order to maintain safety for the patient and others.*

Findings

Interviews

A. Complainant: Recipient 1 was coughing for a few days and was admitted to the hospital from the primary care physician's (PCP) office on 12/11/17 with pneumonia and discharged on 12/13/17 with oral antibiotics prescribed. Her oxygen was low the next day and she was taken back to the emergency department. Staff from the CILA home were told that she needed to be admitted but they would be required to sit with the recipient for the duration of her admission before the hospital would admit her. A sitter had not been required during the first hospital stay, but she had been non-compliant with her intravenous therapy (IV). On 12/15/17 the recipient had some aggressive behaviors and the physician ordered 2 doses of Ativan through her IV around 6:00 a.m. Around 7:45, her breathing became rapid. The physician checked her and believed it was due to anxiety. She had labored breathing for several hours after this, but the physician never returned to check on her. The nurse was concerned and called the physician who ordered more lab work and a chest x-ray around 2:00 p.m. Around 4:30 p.m. the recipient was transferred to another hospital for higher level of care. The complaint stated there were some disagreements between the physician at UCH and the receiving hospital as to whether the recipient would be intubated prior to leaving UCH. After arriving at the other hospital, the recipient was in the intensive care unit (ICU) and then progressive care unit (PCU) before being discharged back to her home.

B. Quality Assurance (QA) Representative: The allegations were discussed with UCH's QA representative in March 2018. The QA representative told the HRA that recipient 1 was admitted from the physician's office with stomach pain. She did not require a sitter during the initial stay. The recipient would remove her IVs but there was nothing remarkable that required emergency medication for maladaptive behaviors. She was discharged on the 13th because her health had improved at that time. On the 14th she returned with low oxygen levels and was admitted with pneumonia and sepsis. The physician's admission orders stated that the recipient needed to have a sitter. The QA representative stated that it is not standard procedure to have a sitter for a person with developmental delays, and it only occurs upon a physician's order. A nurse can recommend it as well, but it is not standard procedure for every patient with disabilities. The QA representative gathered, from the interviews she had conducted internally regarding this situation, that it was due to her occasional need of a 1:1 staff. The QA representative explained that at the time of this incident, the hospital had 4 employees contracted on an as needed basis that had agreed to provide sitter services and had been trained. They contacted them when the need arose and if available, they would provide sitting services. On this date, none of them were available, so the protocol is to contact the on-call nurse to fill that role. She explained that they are now training clinical staff to be used as sitters and they also had 7 non-clinical staff who had agreed to provide that service for pay as needed. During internal interviews, the QA representative discovered that the House Supervisor called their list of potential sitters, but none were available, however the hospital's House Supervisor failed to

document those calls. After having no success obtaining a hospital provided sitter she asked the CILA home house manager to provide a sitter for the recipient. Since there was no documentation of the calls, the HRA asked and the QA representative conceded that it is possible that nursing staff could have just assumed that CILA staff would provide sitter services and did not ask anyone else. The hospital typically offers the option to family and/or staff to provide sitter services themselves if family and/or staff feel like the patient would be more comfortable with familiar people. During internal investigations, the QA representative asked the ED Nurse, House Supervisor and the physician if they felt like the recipient was being denied admission if a sitter was not provided; all said no that she would be admitted and was not being denied. They have since published a brochure for non-hospital staff sitters. This brochure is given to sitters and the provision is documented.

Regarding the other allegation of inadequate care, the QA representative said that according to her records, the recipient was given 2 mg of Ativan through her IV for anxiety at 1:39, 4:49 and 8:58 a.m. If she had complications from the Ativan administration, there is no documentation to indicate that. The recipient came back on 12/29/17 and 1/5/18 for follow up x-rays and both still showed pneumonia and her primary care physician was notified.

C. CILA Staff: The staff person told the HRA that when recipient 1 was initially taken to the hospital no CILA staff were required to stay with her, but they would check on her during mealtimes and after work until she went to sleep. She was noncompliant with her IV during this stay and would remove the IVs, but she was not aggressive. She was released on oral antibiotics and was sent home to recover. A day or two after discharge, she was feeling ill with a fever and her physician said to take her to the ED. When she was brought to the ED the second time, the nursing supervisor told her "we can't keep her here without a sitter." The nursing supervisor did not offer to provide a sitter and told the staff that if they did not have a staff available to sit with the recipient then she would see if the primary physician would transfer her. The ED was full that day. She was admitted, and staff stayed with her until about 10:30. Then, midnight shift staff came in and stayed overnight to monitor her IV. When the nurse's shift changed, and she took vital signs, the recipient woke up and tore out her IV, turned over a table, and pulled the curtain down. This staff person came back in around 5:30 a.m. The nurses had given her Ativan every 4 hours starting around 2:00 a.m. After the 6:00 a.m. dose she noticed the recipient had labored breathing. The physician thought it was an anxiety attack, so he ordered more Ativan for anxiety around 7:30- 8:00 a.m. The staff stated that the recipient had never had an anxiety attack before and she did not think that was the issue. She had also looked up Ativan side effects online and found that it can cause hyperventilation and irregular breathing which concerned the staff member. The nursing supervisor and another nurse stayed in her room for 45 minutes monitoring her breathing after the 6:00 a.m. Ativan dose. The nursing supervisor was concerned and called the physician. He ordered a breathing treatment for the recipient. There were no new orders or actions between 10:00 a.m. and 12:30 p.m. except for blood gases being taken around noon before the physician came in. The nurse then called the physician and asked him to come

to the hospital and examine the recipient. The recipient was not able to eat lunch. The physician came in after lunch to check on her. The physician seemed upset that he had to examine the patient and insisted that it was behavioral. When this staff told the physician, she did not think it was behavioral he replied, "I'm her doctor!" and left the room. After returning to her room, the physician turned her oxygen down to see what she would do, and her oxygen dropped immediately. After that he said he would inquire about transferring her. She was transferred around 4:00 p.m. This staff was under the impression that the receiving hospital's physician was upset upon her arrival because she was not intubated prior to transfer. She was intubated at the receiving hospital around 12:45 a.m. and was on a ventilator for approximately 6 days.

D. Receiving Hospital Staff: The HRA interviewed several staff at the receiving hospital including the Hospitalist who treated recipient 1, Quality Manager, Chief Nurse, System Compliance Manager and Quality Assurance Nurse. The Hospitalist spoke with the primary care physician (PCP) and a pulmonologist. The PCP stated that the recipient did not need intubation but that she might later. The Hospitalist was not expecting her to be intubated upon arrival. She was admitted to the progressive care unit (PCU) for pneumonia, placed on antibiotics, oxygen and steroids. In the middle of the night she was intubated and moved to the ICU and was discharged on December 22nd. Upon admission the recipient was confused, agitated and kicking at staff. This hospital determines sitters on a case by case basis. It was determined that she needed a sitter while in the PCU due to her agitation and this hospital provided one. After she was moved to the ICU she did not have a sitter due to the increased level of care and staff close by. The recipient did have some agitation while on the vent and soft restraints were utilized on December 16th at 1:00 a.m. right after intubation to keep her from pulling at her tubes. Nothing else was documented as extraordinary behavior.

Ativan is not typically prescribed for agitation at this hospital. They try utilizing a sitter first, then diversion before calling the physician for medication. The hospitalist stated that if Ativan is utilized, physicians try to minimize it to a one-time dose. For this recipient, 1 mg of Ativan was given at 8:36 p.m. via IV then she was intubated and was on a Versed and Propofol drip. Ativan is not typically given if a patient is in respiratory distress. If Ativan is used for anxiety it can be helpful, but if it is for sedation, that is a different case. The Hospitalist explained that a typical dose of Ativan for agitation and/or hyperventilation is 0.5-1 mg one time and can be given every 3-4 hours. He typically recommends only giving .5 mg to start with.

E. CILA Nurse: The nurse told the HRA that recipient 1 is typically happy and likes to be around people to talk and she hugs a lot. She was probably scared at the hospital because she is not typically destructive as she was during the second hospital stay. During the first hospital stay she pulled her IVs but did not have any extraordinary behaviors. She was sent home after the first stay with oral antibiotics and her labs had improved. She did fairly well after discharge; she did not have much appetite but was drinking fluids. Her oxygen was satisfactory otherwise they would not have discharged her from the hospital. Sometime before 7:00 a.m. on the 14th she had labored breathing and low pulse oximeter reading (pulsox). It was possible that she aspirated at

night after her initial discharge. When taken to the emergency department, the hospital wanted the CILA home to provide a sitter and would not admit her without one. The House Manager stayed until the CILA owner could be contacted to make other arrangements. Apparently, the hospital did not have staff for a sitter. The recipient was given Ativan for agitation. The physician ordered it and they administered every 2 hours. Her oxygen level was good after the Ativan was given, but she did have labored breathing from the pneumonia. The nurse stated that typically Ativan is given every 4 hours for agitation/anxiety. However, nursing staff would use judgment and monitor, and contact the physician for a new order if necessary. The recipient is typically hyper, but she does not typically have anxiety. The next morning after the recipient destroyed the hospital room at 6:00 a.m., she was anxious, hyperventilating and had rapid breathing. Her pulsox was above 90 at 2 Liters of oxygen. At noon she was worse, in respiratory failure. The nurses called the primary care physician. At 12:30 she was taken for a chest x-ray and blood gasses were also ordered. Her oxygen saturation was acceptable on the blood gas test, so the physician did not intubate her prior to transferring. Around 2:30-3:00 the physician was at the hospital and transferred the recipient to another hospital that could better meet her need for a higher level of care. She arrived at the new hospital around 5:30 and was admitted to the pulmonary care unit (PCU). She was later transferred to the ICU and they intubated her at 1:00 a.m. They monitored her for approximately 8 hours before intubating her.

When asked if there had been issues with other CILA residents at this hospital, the HRA was told of an incident in July 2018 when a resident at another home was sent home because the CILA home did not have enough staff to provide a sitter for her. Staff contacted the CILA home nurse who contacted the hospital and spoke with a hospital nurse. The CILA nurse explained to the hospital nurse that it was not the home's responsibility to provide sitters. The hospital nurse agreed but they sent the patient home anyway. When the patient came home, the hospital had also sent another patients records home with her. The CILA nurse called medical records and notified them of the error. She took the message but said that the privacy officer was on vacation. The CILA home shredded the documents that were sent by mistake.

The CILA nurse described another incident when another resident of the CILA home was hospitalized and the CILA home was able to provide a sitter. The CILA staff reported that the patient was difficult to manage during the stay and the staff felt like the hospital did not take appropriate measures to manage the patient during the stay. The patient was removing IVs and the hospital did not utilize soft restraints to prevent this. The primary physician would have ordered soft restraints if needed, but the hospital never made this request. The nurse speculated that this was possibly due to the extra monitoring and documentation that is required by the Joint Commission on Hospital Accreditation when restraints are utilized. The hospital staff reportedly pressured the primary physician to discharge the patient stating they could not do anything else for her. She was discharged with oral antibiotics and died shortly after discharge.

The CILA nurse stated the primary physician will order sitters for the residents of the CILA homes on a case by case basis but does not order sitters as a "blanket policy."

F. CILA home staff for recipient 2: The staff at this home told the HRA that upon return from a home visit on June 30th, the recipient's sister informed them that she fell outside at her house, but she did not have any injuries. She was monitored and given Ibuprofen for pain. On July 1st she was refusing to walk and required assistance to the restroom. The following day she would not get out of bed by herself. She was taken by ambulance to the hospital for evaluation. Blood work was completed as well as x-rays and it was determined that she had a fractured pelvis. At the emergency department, she was removing her tubes. The ED physician spoke with the primary care physician (PCP) who said that she needed to have a sitter. The CILA home did not have staff to provide sitter services and the hospital reportedly told the home staff that they would not be proceeding without a sitter. The CILA nurse contacted the ED physician who said he was not going to admit her and stated that she should call the primary care physician if the CILA nurse wanted her admitted. The nurse did not call the PCP because the ED physician was the one who evaluated her, and he should make the decision. CILA staff arrived to take the recipient back home. On the way out, one of the nurses told staff that the hospital is required to provide a sitter. The CILA staff returned the recipient home and stayed with her for 13 hours until she could be relieved by another staff person. Since the recipient could not attend work during the day and she was not ambulatory at that time without assistance, a staff person was required to sit with her for 13-hour shifts (8:00 a.m. until 10:30 p.m. and then midnight shift until 8:00 a.m.). This continued for approximately 2 ½ weeks until she was released to obtain physical therapy. At the time of our interview, in August 2018, the recipient was on a 2 week hold with restrictions to monitor and the plan was to discharge her from physical therapy the end of August. The HRA questioned how typical this was for the hospital to require CILA staff to provide sitter services and was told that it is a very common practice at this hospital.

G. Second hospital staff/administration interview: The HRA completed a second site visit in October 2018 to the hospital to question them regarding the allegations involving the second recipient. Administration reviewed records with the HRA and said that she was never considered for admission. The ED physician and PCP spoke and agreed to outpatient care for the recipient, and possibly physical therapy with staff support. The HRA again inquired about the hospital's sitter policy and was told that it is now all being handled "in-house." Certified Nursing Assistants (CNAs) are now serving as sitters. At the time of our interview in October 2018, the hospital had 7 that had been trained to provide sitter services. If more sitters are needed, the hospital will pull from other areas such as administration. The sitters are all trained by reading over materials and by hands on training with supervision. The ED physicians were told that the hospital provides sitters if one is needed. When the need arises, the house supervisor or Chief Nursing Officer should be contacted. If there is one available on call, they will utilize that person; if not, they are to pull from another assignment. The hospital staff will ask the CILA home staff first if they want to provide the sitter service for the comfort of the patient because some patients respond better to familiar people than strangers. If the CILA chooses not to provide the service or cannot due to staffing, then the hospital will provide a sitter.

Record Review

A. Hospital internal investigation summary for recipient 1: The hospital summary stated that on 12/11/17 the recipient was admitted from her PCP office for complaints of stomach pain. On 12/12/17 at 10:30 p.m. it was documented that they were unable to obtain IV access and updated the PCP who stated he would see her in the morning. On 12/13/17 she was discharged back to her CILA. The hospital course stated that she was admitted with community-acquired pneumonia, started on IV Levaquin, given IV hydration and aerosol treatments and did require oxygen initially. She developed significant bronchospasm so was started on IV steroids on 12/12/17. She was afebrile throughout, wheezing improved with steroids and aerosol treatments. She was well oxygenated and "obviously feeling much better by the morning of December 13, 2017." She was taking oral medicines and treatments well. There were no complications noted during the hospital stay. She was discharged to her CILA home on 12/13/17 in an improved condition. On 12/14/17 at 7:21 a.m. it was documented that the recipient returned to the emergency department "continuing to cough and has low O2 stats." Several tests including blood gasses and a chest x-ray were done and it was noted that she had "stable appearance of the chest with bilaternal [sic] pneumonia/edema and pulmonary vascular congestion." Hospitalization was ordered for pneumonia and possible sepsis. At 11:15 a "ED RN placed note" documented that a nurse on "MedSurg" was called to request a bed assignment and the nurse stated that she "would need to come and speak with the caretaker from [CILA home] to verify that a 24/7 sitter would be provided for the pt, per [PCP] before a bed could be assigned." At 12:10 p.m. a bed was assigned, and the recipient was admitted. On 12/15/17 it was documented that at 11:21p.m. the PCP was updated on vital signs and status and he ordered a chest x-ray. It was noted that the recipient "has a sitter at bedside." The chest x-ray confirmed bilateral pneumonia. A note at 1:29 p.m. documented that "respirations and pulse remain increased." At 2:08 p.m. nebulizer therapy was done, and it was noted that the blood gasses drawn earlier were "unremarkable" but she was coughing and hyperventilating. At 2:30 p.m. the PCP was called with an update that the "patient condition has worsened since this am." At 3:00 p.m. the PCP's office returned a call stating they are waiting for another hospital to accept the patient. At 3:08 p.m. the PCP was on the floor with the patient. At 3:22 the recipient was accepted at the receiving hospital for bilateral pneumonia that is not improving. At 3:55 p.m. the emergency medical service (EMS) arrived for transport.

Some other facts listed on this summary stated that the nurse "called multiple employees to try to find a sitter." However, that contact was not documented. The ED staff involved in this patient's care all stated that at no time was an admission refused nor did they feel like the patient would not be admitted, however there was no documentation of conversations to validate their statements. This internal investigation determined that the root cause of the complaint was due to miscommunication. The hospital staff believed that CILA staff volunteered to stay with patient, but reportedly, CILA home staff believed that they were required to stay with the patient

or she would not be admitted. Another root cause was staffing issues as the nursing supervisor stated she contacted staff to sit but was unable to find someone.

This summary noted that there was also a Department of Public Health investigation conducted regarding this allegation between 2/5 and 2/8/18. The results of that investigation were unfounded because the patient was admitted.

B. Medical records for recipient 1: The HRA also reviewed medical records including the discharge summary, progress notes, and history and physical; much of which is listed in the above summary of the internal investigation. Additionally, the HRA reviewed the medication administration record (MAR) for Ativan administration. The MAR showed that on 12/15/17 the recipient received 1 mg intravenously at 1:39 a.m.; 1 mg at 4:49 a.m.; 1 mg at 7:00 a.m.; 1 mg at 8:58 a.m. and 1 mg at 1:15 p.m. The HRA also reviewed ED physician documentation which showed the recipient was presenting with possible pneumonia complications. On 12/14/17 at 7:44 a.m. it stated that she "was recently admitted and discharged from UCH because of pneumonia, continuing to cough and has low O2 sats. Onset: The symptoms/episode became worse last night. Severity of symptoms: At their worst the symptoms were severe in the emergency department the symptoms are unchanged. The patient has been recently seen by a physician." After tests came back abnormal, the PCP was contacted at 11:14 a.m. and the notes indicate that he ordered hospitalization. There was no mention in the note that he ordered a sitter for the recipient.

C. Medical records for recipient 2: The ED documentation showed that the recipient arrived at 10:05 a.m. with complaints of trouble walking. After an evaluation, the diagnosis was a fracture versus contusion. The recipient's PCP "was called at 12:35 p.m. regarding the patient's condition, outpatient follow-up, in 2-3 days, will d/c to out pt care as long as staff supportive." The disposition documented by the ED physician stated "discharged to home, impression: Developmental disorder of speech and language, unspecified hypokalemia, other specified fracture of right pubis, initial encounter for closed fracture. Condition is Stable…follow up: [PCP] 2-3 days; Reason: recheck today's complaints, continuance of care, manage out pt care." The HRA did note several "strike-through" documentations in the record indicating errors in documentation but nothing that seemed to contradict what was documented in the permanent record.

D. CILA home notes: The HRA reviewed notes from the July incident regarding recipient 2. On 6/30/18 the recipient returned from a home visit and her family notified CILA staff that she had a fall. Staff monitored for a couple of days and gave her ibuprofen for the pain. The 7/2/18 afternoon note from the house manager stated that the recipient was escorted by ambulance to UCH that morning. She could not stand alone, and it took 3 staff to get her up and sitting in a chair. Upon arrival at the hospital, the recipient was "yelling and screaming wanting to go home." The physician came in and told the CILA staff that she could be admitted but had to have a sitter. The hospital staff *"didn't tell [home] staff that they [hospital] had to provide a*

sitter [CILA name] didn't have staff at this time. [recipient] was released from hospital and staff brought her back to [CILA home]. While at the hospital, [recipient] tried to pull IV's out, when staff intervened she scratched staff on left arm and when staff tried to stop her again she jerked staffs arm. This was an ongoing thing until we left to come back to [CILA home]." Another note from the Residential Services Director (RSD) on 7/2/18 stated *"RSD called [PCP] office to ask if he would admit [recipient] into hospital. His nurse came back in and told RSD unless I had 24-hour staff to stay with her then no. That she was too erratic to keep in hospital, so they sent her home."* A 3:30 p.m. note from the House Manager stated that the recipient had returned home with staff. She was sitting in a wheel-chair "because she can't bear weight hardly." On 7/9/18 the recipient was seen by her PCP who ordered her to physical therapy and ordered a bone density test.

Policy Review

The Union County Hospital's Patient Rights and Responsibilities policy states that patients have a right for care or services to be provided without discrimination related to physical or mental disability and that patients have a right to *"participate in decisions about your care, including development of your treatment plan, discharge planning and having your family and personal physician promptly notified of your admission."* The policy requires that patients be *"free from neglect; exploitation; and verbal, mental, physical and sexual abuse [and be in] an environment that is safe, preserves dignity and contributes to a positive self-image. Be free from any forms of restraint or seclusion used as a means of conveniences, discipline, coercion or retaliation; and to have the least restrictive method of restraint or seclusion used only when necessary to ensure patient safety."*

The hospital's policy on sitter responsibilities states that "*It is the policy of Union County Hospital to provide a sitter when deemed necessary to maintain a safe environment for the patient and others…sitter usage may be requested by the House Supervisor after the patient is determined to meet the need for sitter services. A physician may authorize the use of sitter services."* The policy continues to state that *"once a sitter need is determined, the nurse will obtain a physician's order for a sitter and document in the nurse's notes reasons a sitter is needed. The House supervisor will review the option for the patient to have a family member or a familiar person to sit with them to assure the patient's safety. It is the responsibility of the House Supervisor to assure that a sitter is obtained from the list of available staff and log all calls made. The RN/House Supervisor will ensure any non-hospital employed sitters are provided handouts on hospital policies and that all education is documented. It is the responsibility of the RN/House Supervisor to assure that the sitter gets scheduled breaks, meal times and an opportunity to address personal needs when necessary. The House Supervisor will*

assign someone to sit with the patient during the sitter's break times. The need for continued sitter services will be re-evaluated every twenty-four (24) hours or earlier as deemed necessary by the attending physician. Documentation in the patient's record will support use of or cancellation of the sitter." The hospital also provided the HRA with a brochure and a training/reference guide that are used for non-hospital employed personal sitter orientation. This brochure clarifies what the sitter responsibilities are and familiarizes them with hospital codes and other pertinent information.

The hospital has a policy on amending the contents of a patient's medical record which was reviewed by the HRA.

The Electronic Health Records (EHR) section states that *"B. The amendment must be made in the source system (where it was originally created) as well as in the long-term medical record or data repository system if applicable.* ***C. Maintain the original incorrect entry or documentation and add the corrected entry or companion document to it****...Exceptions: 2. Errors in charting identified by the author will be corrected in the body of previously charted text by using the single line, initials and current date with re-charting of corrected information at the bottom of the page using 'Late Entry'. Errors in charting identified by the author will be corrected in the source system, if functionality is available. If functionality does not exist, the above proper process will be utilized, as well as any other system in which the information is maintained. 3. The addition of information not documented at the time of the encounter shall be documented in a similar manner by the health care professional. 'Late Entry', the current date and the information shall be documented at the bottom of the last page of documentation (i.e., last page of nursing notes, progress notes, etc.). For the electronic health record, the amendment shall be documented in the source system as a correction to the original, if functionality is available; otherwise the above proper process will be utilized."*

Statutes

Hospital Regulations (77 IL ADC 250.2280) state that *"a) The "Mental Health and Developmental Disabilities Code" effective January l, l979, as hereafter amended - Public Act 80-l4l4 shall apply to the care of patients…"*

Pursuant to the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102):

"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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient."

The Medical Patient Rights Act (410 ILCS 50/3) establishes the following rights *"(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by*

law… (d) The right of each patient to privacy and confidentiality in health care. Each physician, health care provider, health services corporation and insurance company shall refrain from disclosing the nature or details of services provided to patients, except that such information may be disclosed: (1) to the patient, (2) to the party making treatment decisions if the patient is incapable of making decisions regarding the health services provided, (3) for treatment in accordance with 45 CFR 164.501 and 164.506, (4) for payment in accordance with 45 CFR 164.501 and 164.506, (5) to those parties responsible for peer review, utilization review, and quality assurance, (6) for health care operations in accordance with 45 CFR 164.501 and 164.506, (7) to those parties required to be notified under the Abused and Neglected Child Reporting Act1 or the Illinois Sexually Transmissible Disease Control Act,2 or (8) as otherwise permitted, authorized, or required by State or federal law. This right may be waived in writing by the patient or the patient's guardian or legal representative, but a physician or other health care provider may not condition the provision of services on the patient's, guardian's, or legal representative's agreement to sign such a waiver."

Hospital Regulations (77 IL ADC 250.1510) require that *"2) An adequate, accurate, timely, and complete medical record shall be maintained for each patient… 4) A committee of the organized medical staff shall be responsible for reviewing medical records to ensure adequate documentation, completeness, promptness, and clinical pertinence… e) Preservation 1) All original medical records or photographs of records shall be preserved in accordance with Section 6.17 of the Act. 2) The hospital shall have a policy for the preservation of patient medical records if the hospital closes."*

Conclusion

The allegations involve two different recipients. The complaint alleged that Union County Hospital provided inadequate care and treatment to recipient 1 by discharging her prematurely and not responding quickly enough with treatment during the second hospital stay when her condition worsened. Another concern was that the Ativan administered could have contributed to the labored breathing. Upon review of the records and interviews, the HRA found that the recipient was discharged on December 13th and readmitted the following morning on the 14th for the same issue which was pneumonia. The discharge summary dated 12/13/17 stated that *"her course was one of improvement"* and documented that wheezing improved with steroids and aerosol treatments. According to the discharge summary, she was well oxygenated and *"obviously feeling much better by the morning of December 13. She was taking oral medicines and treatments well."* She was discharged to the CILA home that morning *"in improved condition."* She returned to the ED on December 14th presenting with *"possible pneumonia complications and low O2 sats."* The recipient was admitted and eventually transferred to another hospital for a higher level of care where she remained for approximately a week. She was intubated and in both the PCU and ICU at the receiving hospital. All hospital documentation from the initial stay showed improved condition prior to discharge. The CILA home nurse when interviewed also stated that the recipient could have possibly aspirated

overnight at her CILA home causing the pneumonia to worsen. It is beyond the scope of the Authority to determine if more could have been done medically prior to discharge or if the patient had complications unrelated to treatment requiring her to be readmitted the following day. Since all documentation indicated improved condition prior to discharge this portion of the allegation cannot be substantiated.

The other aspect of this allegation was that the physician did not respond with treatment quickly enough during the second admission and whether the Ativan dosage contributed to worsened breathing. A review of the records showed that the recipient was given 2 mg of Ativan through her IV for anxiety at 1:39, 4:49 and 8:58 a.m. Labored breathing began that morning and a nebulizer treatment was given. The nursing notes documented that the physician was called at 2:30 p.m. to notify that her condition had worsened since the morning. The physician was on the floor at 3:08 p.m. at 3:55 p.m. the recipient was transferred to another hospital for higher level of care. The HRA contends that once notified, the physician responded appropriately, and documentation also showed the nursing staff kept in contact with the physician throughout the morning prior to him coming to the hospital to assess the patient. Regarding the Ativan administration, the Hospitalist at the receiving hospital explained that a typical dose of Ativan for agitation and/or hyperventilation is 0.5-1 mg one time and can be given every 3-4 hours. While at their hospital, the recipient only received one-1 mg dose of Ativan prior to intubation. At UCH, the recipient received 6 mg of Ativan over the course of 7 hours. While there was some evidence to suggest that this dose may have been a contributing factor to labored breathing, because that is a potential side effect of Ativan, it is beyond the scope of the authority to determine appropriate medications for specific situations. Therefore, this allegation is **unsubstantiated**. The HRA offers the following suggestions:

1. Quality Assurance and Administration should review the Ativan dosage that was given and the surrounding circumstances and take appropriate actions to retrain or otherwise correct the error if the dosage was determined to be an error.

2. This is the second HRA investigation of UCH where chart documentation/medical record errors occurred. The HRA discussed this with administration during the site visit and was informed that the hospital is converting to a new electronic record keeping system which will hopefully decrease the occurrences of errors. However, they also stated that it would be approximately a year before it was fully implemented. The HRA suggests that Quality Assurance and Administration discuss and implement interim solutions to documentation errors as mis-diagnoses could potentially follow a person in medical records; such a review could also help ensure that all practices are complaint with Hospital Regulations (77 IL ADC 250.1510).

3. The HRA was also concerned that in both HRA investigations there were also instances of other patients' records being sent to the wrong person which is a HIPAA

violation. The CILA home in this case shredded the incorrect records and reported it to the hospital but was unsure if any corrective measures were taken. The HRA suggests that Quality Assurance review that error as well and determine if further training or other measures should be taken to prevent such errors in the future to ensure that patient rights to confidentiality are protected as required by the Medical Patient Rights Act (410 ILCS 50/3).

4. Administration and/or Quality Assurance should address the alleged inappropriate bedside manner of the physician and ensure that interactions with patients and family are appropriate and professional.

In reviewing the second allegation, the HRA determined that recipient 1 was denied admission to the hospital unless the CILA home staff provided a sitter to supervise for the duration of her admission. According to hospital documentation, recipient 2 was not considered for admission and the physicians agreed to send her home with outpatient care. At the time of interviews regarding the first recipient, Quality Assurance staff informed the HRA that the hospital's policy was to provide sitters from a list of trained workers who were on call. If none were available, as in this case, then the nurse on call was to provide the sitter service. The supervisor on duty stated that she contacted the people on this list, but none were available, however she failed to document those contacts and there was no documentation to indicate that the on-call nurse was contacted to fill the sitter role for this recipient. The CILA staff informed the HRA that the nursing supervisor told her that the hospital could not admit the recipient without a sitter and did not offer to provide a sitter. Instead the nurse said that she would see if the PCP would transfer the recipient. The hospital's internal investigation summary documented that an ED Nurse called a floor nurse for admission and the floor nurse stated that she would need to speak with the caretaker from the CILA home to verify that a 24/7 sitter would be provided for the patient before a bed could be assigned. This statement indicates that the nurse believed it was the CILA home's responsibility to provide a sitter. The CILA home documentation regarding the second recipient indicated that the PCP's office also believed that it was the CILA home's responsibility to provide a sitter because when the RSD from the home contacted the PCP requesting admission, she was informed that admission was denied unless she had 24-hour staff to supervise. The hospital policy states *"once a sitter need is determined, the nurse will obtain a physician's order for a sitter and document in the nurse's notes reasons a sitter is needed. The House supervisor will review the option for the patient to have a family member or a familiar person to sit with them to assure the patient's safety. It is the responsibility of the House Supervisor to assure that a sitter is obtained from the list of available staff and log all calls made."* In this case, the nursing supervisor did not document that he/she notified the home staff that the hospital would provide a sitter. There was also no documentation found where calls to the "on call sitters" were made or if a call to the on-call nurse was made to fill the role as hospital policy requires. Although it did not appear that discrimination occurred

because it is not a blanket practice for all individuals with developmental disabilities to be required to have a sitter, the HRA did find violations of the hospital's policy on patient sitters. Therefore, this allegation is **substantiated**. The HRA makes the following **recommendations**:

1. **Any staff involved in finding a sitter or providing sitter services should be retrained on the hospital's policy and reminded that it is the hospital's responsibility to provide a sitter not the family's or CILA home staff's responsibility.**

2. **The PCPs who have privileges at this hospital as well as their office staff should also be made aware of the hospital's sitter policy.**

3. **Physician orders for sitters should be clearly documented in the patient's medical record.**

The following suggestion is also made:

1. Literature given to patients and/or family members or caretakers should include information on hospital provided sitters to reduce or eliminate miscommunication between hospital staff and patient's family or caretakers.

2. While the HRA recognizes that the term, "sitter," is not purposely being used to indirectly and negatively describe individuals with disabilities, the HRA suggests that the hospital review the literature on how language, specific to persons with disabilities, has evolved to portray persons with disabilities and the services that they receive in a more respectful manner. The terms, "Personal Assistant", "Aide" or "1:1" etc. are often used for such services.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 18-110-9009

SERVICE PROVIDER: Union County Hospital

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document may be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

✓ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Jim Farris
NAME

Jim Farris, CEO
TITLE

2/25/19
DATE

517 North Main Street
Anna, Illinois 62906
Phone: 618.833.4511
Fax: 618.833.9641

February 25, 2019

Kim Conway, HRA Coordinator
Human Rights Authority
Egyptian Regional Office
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case#18-110-9009

Dear Ms. Conway:

Union County Hospital has completed its review of the recommendations made by the Egyptian Regional Human Rights Authority of Illinois Guardianship and Advocacy Commission regarding the case referenced above. We appreciate your assistance and recommendations in this matter. Union County Hospital is committed to providing high quality patient care. Along these lines, we submit the following:

We understand that of the two allegations, the HRA found one to be substantiated (Inadequate care and treatment of a patient). We believe that the patient did receive adequate care but the communication process surrounding this situation needs to be enhanced. This incident involved a communication breakdown regarding accommodating the need of patient sitters when one is required per physician order. The HRA recommendations were made, "Any staff involved in finding a sitter or providing sitter services should be retrained on the hospital's policy and reminded that it is the hospitals responsibility to provide a sitter not the family's or CILA home staff responsibility. Physician orders should be clearly documented in the patient's medical record. The PCP's who have privileges at this hospital as well as their office staff should also be aware of the hospital's sitter policy."

In response to this recommendation, Union County Hospital has developed the Patient Sitter Guidelines and Training program. These guidelines and training were put into effect January 18, 2018. All staff will receive follow-up education and training annually regarding the sitter program. There is also a sitter call log to monitor contacts to staff in order to obtain sitters for patients.

Union County Hospital has also reviewed the HRA suggestions with regards to the unsubstantiated allegation. We appreciate this information and will be taking each into consideration with our Medical Staff and Governing Board.

If you have further questions or concerns, please do not hesitate to let us know.

Sincerely,

James R. Farris, FACHE
Chief Executive Officer