



State of Minnesota
The Office of Ombudsman for
Mental Health and Developmental Disabilities
Delay of Treatment



This Medical Alert is based on the work of the Office of Ombudsman for Mental Health and Developmental Disabilities Medical Review Subcommittee and should be posted prominently. The Office of Ombudsman for Mental Health and Developmental Disabilities works to improve the services provided to people with disabilities by communicating important information found in the Medical Review Subcommittee's reviews of deaths and serious injuries. Thank you for promptly reporting deaths and serious injuries. You are helping us to meet our mission.

Using a list of 10 screening guidelines developed by the Medical Review Subcommittee (MRS), the Medical Review Coordinator determines whether or not a death requires a review by the Medical Review Subcommittee. One of the screening indicators is **“A death of a person receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.”**

Every year a significant number of reported deaths meet this indicator for review by the MRS.

Most often, a client is recognized to have a “cold” or “upper respiratory infection,” and over-the counter or “standing order” medications are administered to treat signs of illness. Sometimes the client is treated with alternating doses of both Tylenol (acetaminophen) and Motrin (ibuprofen) for a number of days before the client’s primary medical provider is contacted by residential staff. Please refer to the following Alert on the Ombudsman’s website: *Use of over-the-counter medications and possible delay of treatment.*

Sometimes a client, who lives independently, is seen by a case manager, mental health provider, or home health aide and is advised to seek medical attention, but the client does not follow that advice and is soon after found dead. While a client most often has a right to refuse medical treatment, there may be other factors that impede the client from obtaining care: lack of transportation, fatigue, disorientation, etc.

Sometimes, the client is seen by his or her primary health care provider and is sent home with a prescription for antibiotics and an order to return to clinic if symptoms persist, only to die within hours or a few days of the clinic visit.

Sometimes obviously ill clients are sent to their day programs, and day program staff contact the residential staff for advice or call 911.

Sometimes staff recognize a serious problem with a client and attempt to transport the client to the Emergency Room in a facility vehicle without calling 911. Sometimes those clients are pronounced dead on arrival (DOA) at the emergency room. The American Heart Association advises the following:

Calling 9-1-1 is almost always the fastest way to get lifesaving treatment. Emergency medical services (EMS) staff can begin treatment when they arrive — up to an hour sooner than if someone gets to the hospital by car. EMS staff are also trained to revive someone whose heart has stopped. Patients with chest pain who arrive by ambulance usually receive faster treatment at the hospital, too. It is best to call EMS for rapid transport to the emergency room.

Occasionally, we will see a case in which providers have carefully documented the client's decline, but do not call 911 until the client stops breathing. This office recommends that residential staff be trained to recognize breathing problems. Remember very loud irregular snoring breaths, gasping, apnea (breathing that slows down or stops from any cause), and agonal respirations (defined as irregular, gasping breaths often seen during cardiac arrest), do not provide adequate oxygen to the body and should be considered the same as no breathing at all.

Residential staff should be trained to monitor clients for changes in their health. Many facilities have staff who are trained to obtain the client's "Vital Signs" before calling a nurse or the client's primary health care provider. Other residential facilities rely on staff knowing when to transport the client to his or her primary health care provider or to Urgent Care for a professional medical assessment.

Vital signs from Medline Plus

Vital signs include the heart beat, breathing rate, temperature, and blood pressure. These signs may be watched, measured, and monitored to check an individual's level of physical functioning.

Normal vital signs change with age, sex, weight, exercise tolerance, and condition.

Normal vital sign ranges for the average healthy adult while resting are:

- Blood pressure: 90/60 mm/Hg to 120/80 mm/Hg
- Breathing: 12 - 18 breaths per minute
- Pulse: 60 - 100 beats per minute
- Temperature: 97.8 - 99.1 degrees Fahrenheit / average 98.6 degrees Fahrenheit

From <http://www.nlm.nih.gov/medlineplus/ency/article/002341.htm>

Please review the following cases to see a few examples of a Delay of Treatment:

Case #1

A client with developmental disabilities, who lived independently in the community, complained of chest pain to the staff members at his DT & H. (He was an older, overweight male with a high cholesterol level and insulin dependent diabetes mellitus.) His staff person accompanied the client to his physician's office. By the time they arrived at the physician's office, the client was sweating, pale, and short of breath. The physician assumed the appointment was for a follow-up to a previous visit for a sinus infection and failed to perform an EKG. The next day, when the client again complained of chest pain to his DT & H worker, the staff person called an affiliated clinic for a second opinion, but reached the original physician, who then ordered Tylenol Extra Strength for the client's chest pain. The man died of a cardiac arrest in his home four days later.

MRS recommendations for Case #1: The MRS concluded that the DT & H staff had acted assertively and in good faith in their attempts to obtain medical care for their client. It is not surprising that staff persons, who often do not have training in medical or nursing assessment, would rely upon the advice of a physician. This case illustrates the importance of a staff person to **clearly communicate to the medical provider the purpose of the medical visit.**

It also illustrates the importance for all staff persons who work with vulnerable clients to **be aware of the risk factors for heart disease** and to **advocate for appropriate assessment of your clients** who complain of chest pain. Clinical resources consider the EKG to be the critical first test for any adult experiencing chest pain. One clinical resource recommends that the EKG be administered within the first five minutes of a clinic visit for an adult complaining of chest pain.

Warning Signs of a Heart Attack (from the American Heart Association)

Some heart attacks are sudden and intense — the “movie heart attack,” where no one doubts what’s happening. But most heart attacks start slowly, with mild pain or discomfort. Often people affected aren’t sure what’s wrong and wait too long before getting help. Here are signs that can mean a heart attack is happening:

Chest discomfort. Most heart attacks involve discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. It can feel like uncomfortable pressure, squeezing, fullness or pain.

Discomfort in other areas of the upper body. Symptoms can include pain or discomfort in one or both arms, the back, neck, jaw or stomach.

Shortness of breath with or without chest discomfort.

Other signs may include breaking out in a cold sweat, nausea or lightheadedness.

As with men, women’s most common heart attack symptom is **chest pain or discomfort**. But women are somewhat more likely than men to experience some of the other common symptoms, particularly **shortness of breath, nausea/vomiting, and back or jaw pain**. Learn about the [warning signs of heart attack in women](#).

Learn the signs, but remember this: Even if you’re not sure it’s a heart attack, have it checked out (tell a doctor about your symptoms). Minutes matter! Fast action can save lives — maybe your own. Don’t wait more than five minutes to call 9-1-1 or your emergency response number.

Please check the American Heart Association’s website for additional information on heart attacks and strokes at <http://www.americanheart.org>.

Case #2

One day after receiving a flu shot, a client with a mental illness, who was receiving services in a state operated facility, developed a fever. The nursing staff, by phone, because it was the weekend, obtained a physician’s order for aspirin and frequently assessed the client. He died Sunday evening after a cardiac arrest caused by severe pneumonia.

*MRS recommendation for Case #2: **When your client has a change in physical health, do not delay a face to face assessment by a qualified professional.*** It’s easy to think that the client will “get better by morning or by Monday,” and sometimes it seems that staff are unofficially discouraged from calling the medical provider or on-call supervisor late at night or on the weekend. Please don’t make that mistake with your client.

Case #3

A client with mental health and a seizure disorder had stayed home from his DT & H for two days. He then refused to take his medication. Overnight, he appeared “pretty sick,” according to staff reports. In the morning, he was taken to his clinic and admitted to the hospital where he suffered a heart attack and died. After his death, it was discovered that he had pneumonia.

MRS recommendations for Case #3: Call your supervisor or seek medical attention for your client when his or her behavior changes. Many of our clients cannot tell you “where it hurts” and many may appear to have a high pain tolerance. In addition, clinical resources indicate that an infection (like pneumonia) in the elderly and in our clients with hypothermia may not immediately produce a “fever.”

Case #4

A 49-year-old man, with schizoaffective disorder, obsessive compulsive disorder, diabetes, metastatic colon cancer, a history of a pulmonary embolism on anticoagulants, and other medical conditions, died on the day he was hospitalized for unresponsiveness. His manner of death was an accident, and his immediate cause of death was attributed to complications of a subdural hematoma following a fall. Coumadin for previous pulmonary emboli, colon cancer, and hepatic metastasis were listed on his death certificate as other significant conditions contributing to but not resulting in his underlying cause of death.

Prior to his death, the client had lived in his own apartment with the support of an assertive community treatment (ACT) team. The client was seen every two weeks to receive his Risperdal Consta injection and to have his medications set up and monitored. Nine days before his death, the ACT team’s RN noted a bump on the client’s head. He reported falling and hitting his head on the sidewalk. He denied loss of consciousness, headache, nausea, vomiting, weakness, vision problems, or dizziness, and his pupils were equal and reactive to light. The RN discussed with the client the issue of head injury, symptoms to watch for, and instructed him to call 911 or go to the hospital/ER if they occurred. The RN saw the client again three days later, and he continued to be asymptomatic from the fall. Four days after that, the client presented to the emergency room complaining of leg and hip pain after working out at the gym. He was diagnosed with muscle strain. During his evaluation, his INR was found to be very high at 10.4. He was given Vitamin K 5mg orally. He was then discharged and instructed to have his INR checked the next day by his doctor or return to the emergency room to recheck it. A family member saw him that evening, and he seemed fine. The next day the family member returned and found him unresponsive. He was taken by ambulance to the hospital where a massive subdural hematoma was found. He was intubated due to impending respiratory failure. Surgical intervention was not deemed feasible. In consultation with family, due to his poor prognosis, he was extubated and died.

MRS Recommendations for Case #4: 1) Clients receiving ACT team services may be in need of additional assistance when monitoring their medications and INR levels. It was reported that the client managed his INR blood draws on his own. The agency may wish to review its policy regarding medication assistance and INR monitoring to clients. 2) Dependent upon the client’s level of understanding, talking about possible consequences of a head injury to a person receiving anticoagulants may be insufficient. In some cases, it may be necessary for an ACT team member to volunteer to take the client to the ER for an assessment.

Bottom Line: There is no substitute for caring, well trained, and well-supported front line staff. You are the first to see a change in your client’s behavior. Your attention to your client, your recognition of a change, and your early call for help just may save your client’s life.