FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Vista Health Systems
Vista Medical Center East
HRA #08-100-9034

Case Summary: The HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Vista Medical Center East. In June 2008, the HRA notified Vista Health Systems of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation were the following:

1. It was alleged that confidential information about some consumers was left out in public for others to see.
2. A consumer on the unit was assaulting others; staff members ignored the behavior by playing computer games.
3. Some staff members were verbally abusive.
4. Some staff members take food items off consumer food trays for their own consumption.
5. The unit was very cold and there were not enough blankets to keep the consumers warm at night; many consumers had no socks and the hospital was unable to provide socks.
6. On one occasion maintenance personnel came to the unit during breakfast; they drilled a hole in the wall which resulted in drywall dust all over, including the food which no one cleaned up.
7. The hospital did not provide soap for bathing.

The rights of consumers receiving services at mental health facilities are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-112) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110).

Background

Vista Health is a network of two hospitals in Waukegan, Vista Medical Center East and Vista Medical Center West. Vista West is a stand-alone same day surgery and treatment center, which has several locations for imaging and patient therapy. Vista East (formerly Victory Memorial Hospital) is an acute care community hospital that has a behavioral health unit.

Method of Investigation

The HRA requested and reviewed hospital policies specific to the allegations. Also reviewed were maintenance records/logs for April 2008. In response to the case opening letter, Vista Medical

Center conducted an internal investigation and provided the HRA with written information on the investigation. In August, the HRA conducted an on-site visit at the hospital to discuss the allegations with the Director of the Psychiatry Program, the Chief Executive Officer, the Manager of the unit, and the Director of Quality Assurance. Also interviewed were three recipients of services. The complainant was interviewed via telephone.

Allegation: It was alleged that confidential information about some consumers was left out in public for others to see.

Findings

The complainant reported that a Medical Physician left a chart on a counter unattended. It was reported that a recipient picked up the chart and read from it.

At the site visit, it was stated that all hospital personnel conform to the requirements of the Health Information Portability and Accountability Act (HIPAA). All medical records and confidential information is secured in the nursing station. The unit was recently remodeled with confidentiality in mind, in that the counter at the nurses station is higher than average, so that charts cannot be easily seen. It was also stated that staff members received mandatory education during hospital orientation and they are required to show annual competency for HIPPAA and Privacy. During the tour of the unit, no confidential information was noted in public viewing.

The hospital's policy for Patient Confidentiality states (in part) that "Information regarding psychiatric patients will be released only with the patient's written consent. In-service training will be provided periodically to hospital psychiatric staff to help maintain an awareness of the provisions of this policy in the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Failure to maintain the confidential nature of business, personnel and protected health information and information in the medical record may be grounds for corrective action up to and including discharge."

Conclusion

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in1996. It establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information about health status, provision of health care, or payment for health care that can be linked to an individual. This includes any part of a patient's medical record or payment history.

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act Section 3,"All records and communications shall be confidential and shall not be disclosed except as provided in this Act."

The HRA cannot discount the claim that confidential information was left for others to see/read, however no evidence was found to support the claim; the allegation is unsubstantiated. The HRA takes this opportunity to remind all staff members on the importance of maintaining confidentiality.

Allegation: A consumer on the unit was assaulting others; staff members ignored the behavior by playing computer games.

Findings

As stated above, it was reported that staff members were busy playing computer games and did nothing to address an out-of control recipient.

Hospital personnel offered that upon their review of this allegation, occurrence reports were evaluated for the month of April and no reported assaults were noted. The staff and leadership staff were interviewed to identify patients that may have been observed assaulting patients or other staff members. It was indicated that a particular patient had a history of violence and had been abusive to staff, but not to any other patients on the unit.

The HRA was informed that staff members are prohibited from playing computer games while on duty. The computers on the unit are EMR (electronic medical recording) and do not have Internet access; administrative offices have Internet access. It was also stated that cellular telephones are not allowed on the unit. Upon receipt of the complaint, the Medical Information Systems Technology Department evaluated computer use during the month of April and did not find any unapproved activity. It was also offered that staff members have CPI (Crisis Prevention Institute) training yearly to assist with behavioral challenged patients.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 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." Section 2-112 of the Code states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The HRA found no evidence to support the claim; the allegation is unsubstantiated.

Allegation: Some staff members were verbally abusive.

Findings

It was stated that at the time of admission, patients are provided with a Patient Handbook which contains information about how to file a grievance. A review of this Handbook showed that a patient is advised that he/she has the right to be treated with consideration and respect for personal dignity, autonomy and privacy. If the patient has a concern or problem, patients are instructed to notify their physician, nurse, therapist, or case manager. If the patient feels that staff are unable to resolve the issue, he/she can contact the Patient Advocate through the main hospital for further assistance. The number of the Advocate is provided in the Handbook. Also provided is the number of a State representative who is responsible for investigating serious complaints (it is noted that the number provided is not complete).

The internal investigation did not find any complaints from patients or patient families regarding verbal abuse from staff members. It was stated that staff members receive mandatory training and education on expectations for proper behavior toward patients that is consistent with the values, the hospital's mission and customer service standards of the organization.

The patients interviewed each stated that staff members are very friendly and no one had heard anything abusive.

The hospital's Patient Abuse policy states (in part) that the Psychiatric Programs take all steps necessary to promote the safety and well-being of patients and, in this regard, to follow a prescribed set of procedures regarding allegations of patient abuse by hospital employees. No patient is to be mistreated or abused in any fashion, either physically or verbally by any employee. Any complaint or evidence that a patient has been mistreated or abused physically or verbally in any fashion will be reported immediately to the director of Behavioral Health by those who initially observed or received the complaint. Pending the outcome of the investigation of the patient abuse allegations, an employee suspected of patient abuse may be detailed to another area of responsibility within his respective service, another area of the hospital or may be placed on suspension."

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 2-112 "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The HRA cannot discount the claim that some staff members were verbally abusive, however no evidence was found to support the claim; the allegation is unsubstantiated.

Allegation: Some staff members take food off consumer food trays for their own consumption.

Findings

At the site visit, it was explained that the meal trays are delivered to the unit via a closed cart. The unit refrigerator is separate from the staff refrigerator. Staff members are prohibited from eating patient food, and staff members had no knowledge of this matter when questioned.

None of the recipients interviewed stated that they saw staff members taking food from a tray for personal consumption.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 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 HRA cannot discount the claim that some staff members take food off consumer food trays for their own consumption, however no evidence was found to support the claim; the allegation is unsubstantiated.

Allegation: The unit was very cold and there were not enough blankets to keep the consumers warm at night; many consumers had no socks and the hospital was unable to provide socks.

Findings

At the site visit, it was stated that Engineering personnel were available 24 hours a day, seven days a week to respond to complaints of this nature. It was stated that the unit has a ready supply of blankets and socks, but should they need more, they can and do borrow from other areas within the hospital. While on the unit, the HRA noted that blankets were readily available in the linen closet and socks were in the supply area; a shipment of socks had just arrived on the unit.

A review of the maintenance records showed that calls were made regarding rooms being both hot and cold and measures were taken to resolve the calls.

In discussing this allegation with the patients, one patient reported that his room was cool and he notified a nurse and someone from the maintenance department arrived shortly thereafter and adjusted the thermostat. Each patient stated that if they were cold, they would ask for extra blankets.

Conclusion

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

At the time of the visit, the unit did not seem cold and it was adequately supplied with blankets and socks. The HRA found no evidence to support the claim that the unit was very cold and there were not enough blankets to keep the consumers warm at night; or that many consumers had no socks and the hospital was unable to provide socks; the allegation is unsubstantiated.

Allegation: Maintenance drilled a hole in a wall which resulted in drywall dust all over, including on food.

Findings

It was written that in April 2008, new thermostat covers were installed in every room with a thermostat. Upon the internal inspection, it was noted that the dining tables were not located near the thermostat. While meeting with hospital personnel, it was indicated there was no thermostat in the area where food is served. During the unit tour the HRA noted a thermostat in the day room where meals are taken. The thermostat was located directly over a table. When this was brought to the attention of staff members, it was stated that the tables are moved together for meals away from the wall where the thermostat is located.

Conclusion

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

Although the HRA was given conflicting information about whether the area where meals are served contained a thermostat, no evidence was found to support the claim that Maintenance drilled a hole in a wall which resulted in drywall dust all over, including on food; the allegation is unsubstantiated.

Allegation: The hospital did not provide soap for bathing.

Findings

During staff interviews, it was indicated that the patients receive a packet of liquid soap, because for safety reasons, mental health patients cannot be trusted with a bar of soap. When empty, they would turn in the packet for another packet. During the unit tour, it was noted that packets of soap were available. Soap dispensers are also located in patients bathrooms. The Unit Manager indicated that patients could get more soap by asking staff.

Each recipient interviewed stated that personal hygiene products are readily available.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 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 HRA found no evidence to support the claim that the hospital did not supply soap; the allegation is unsubstantiated. The HRA takes this opportunity to say that liquid soap can be as easily ingested; thus the comment about the bar soap being unsafe is puzzling.

Comments

Each patient interviewed mentioned that the program lacks structured group activities. It is strongly suggested that the hospital look into the group schedules and possibly offer more groups to hasten patient recovery.

RESPONSE

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

VISTA
HEALTH
SYSTEM

October 31, 2008

Dan Haligas
Chairperson
North Suburban regional Human Rights Authority
Guardianship & Advocacy Commission
9511 Harrison Street, W-300
Des Plaines, Illinois 60016-1565

Re: HRA #08-100-9034

Dear Mr. Haligas:

Thank you for the opportunity to respond to the above complaint. We are pleased that in working with us your review found that none of the alleged complaints were substantiated. Vista Health System is dedicated to providing high quality health care and strives continuously to meet the needs of those we serve. We undertake all opportunities and suggestions for improvement in serious regard and will implement any programmatic changes that may be beneficial for our client population. We appreciate your efforts in addressing these concerns.

Please do not hesitate to contact me should you need anything further.

Very truly yours,

Kimberly M. Page

Kimberly M. Page
Interim Director Quality and Risk Management
Vista Health System