FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Report of Findings
Case 09-060-9005
The Pavilion

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning behavioral health services at The Pavilion located in Champaign, Illinois:

Complaints:

1. A recipient was admitted to a room that had not yet been cleaned.
2. A recipient did not receive needed medication.
3. A recipient was not able to access needed personal belongings.
4. A recipient's private telephone communication was impeded.
5. The facility did not complete needed medical tests.
6. Facility staff behaved unprofessionally.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.) and the Illinois Administrative Code for Hospital Licensing Requirements (77 Ill. Admin. Code 250.1710).

The Pavilion's inpatient program consists of 17 adult beds. The average length of stay is 7-10 days for adults and 10-11 days for children. Per its website, The Pavilion offers comprehensive care to youth, adults, and their families. The Pavilion offers distinct, highly structured inpatient and partial hospitalization programs for the treatment of alcohol, drug, and psychiatric problems. A patient arriving at The Pavilion receives a professional intake assessment, directed by a physician. After the patient's needs are assessed, a treatment plan is recommended. Therapeutic programming includes individual, group and family therapy, activity and recreational therapy, psycho educational groups and medical intervention.

COMPLAINT STATEMENT

According to the complaint, the patient admitted herself to the hospital voluntarily with a history of attempted suicides. She was admitted from [redacted] to [redacted] and again from [redacted] to [redacted] upon a doctor's recommendation. On the second admission, her room was said to be unclean; it had hairballs and food in it but no toilet paper or towels, and, it was not cleaned until the next day at 11:00 am. The complaints state that food, drinks, and a breakfast were not provided; the patient had to listen to one nurse complain about her scheduling and call her

supervisor an inappropriate name; she requested her belongings so she could remove her contact lenses and was told that a nurse would get them later, and she called her husband about her belongings, as a nurse stood behind the outside door, listening to her conversation. Also, there was reportedly a delay in receiving her medicines, Dicyclomine, Lamicil, and Lithium, being told that they do not give out meds until 7 pm although it was already 9:40 pm.

The complaints also state that the patient did not recognize her physician because she did not have her glasses and was unable to put in her contacts. She was upset about her room condition and voiced this to the physician who contacted her husband about discharge and made arrangements for her to receive her medications. She reportedly never received her belongings until she was discharged; the staff claimed they were too busy with too many admits to bring her personal belongings to her. The complaint concludes by stating that a blood test was ordered to test her Lithium levels, but since she could not access her medications, they could not complete the blood work.

FINDINGS

Complaints #1 & #3 A recipient was admitted to a room that had not yet been cleaned and was not able to access needed personal belongings.

Interviews

The HRA met with the Director of Performance Improvements/Risk Management and the Director of Nursing. It was explained to the HRA that the Pavilion has a full-time and a part-time housekeeper. They also have mental health technicians that can assist in this area as well.

The HRA toured the patient rooms and the floor that this patient would have been on. Everything appeared very clean and neat. The HRA was shown the area where a patient's belongings would be kept. It appeared that personal belongings would be easily located and should be accessible to staff if staff would unlock the room so that a patient could access them. We also happened to notice that it was meal time and patients could pick up their meal trays and take them to the day room. The HRA was shown where patients could also take prepared meals out of the refrigerator to which all had access. There was a pantry full of snacks and the refrigerator also had snacks and drinks. The HRA was also told that patients are given four reminders to come and pick up their breakfasts. Information about patient's rights as well as pertinent Office of the Inspector General and HRA information was posted on the wall where patients could see them.

The Authority was advised that contact lenses could be kept in a plastic glass and that the patient's glasses would not be considered contraband. The recipient could have asked the mental health technician or the nurse for her belongings and they would have been provided.

As far as cleaning, the rooms are spot-checked daily, not fully cleaned daily. The HRA was also informed that this was a late admission to the facility.

Record and Policy Reviews

The Authority examined the record of the patient, with consent, and reviewed pertinent hospital policies and related facility mandates. Per the Patient Progress Report, the psychiatrist documented that the patient was refusing to cooperate until she saw and spoke with him. When he had met with her, she had a litany of complaints about how she had been treated the previous night on the unit. Per the psychiatrist's notes some of them appeared to be fairly legitimate. For example, according to the psychiatrist's documentation, she stated that she was not allowed to have her contact solution and contact case and that she ended up having her contacts in four hours longer than normal. She has been apparently asking for her glasses, but staff told her that they were too busy to obtain them for her. She was complaining about the condition of her room, stating that it was not clean. The psychiatrist looked about her room and saw that there were balls of hair on the floor. She was complaining that she did not have any toilet paper. He verified by going into her bathroom seeing that she had an empty toilet paper roll in her wastebasket. He stated in his notes that the patient may have played some role into why she did not effectively advocate for herself in terms of getting her needs met the night before, but staff probably shared some blame in this.

The psychiatrist later documented that the patient felt like she was having a nervous breakdown and in essence told him that she felt much worse since coming into the hospital and that she would do better at home. He did not feel she was able to move beyond this and that this whole experience in the hospital would be negative for her therapeutically according to his notes.

On the patient possession checklist for admission it shows that they had her contact case and a bottle of solution. There was no record of her eye glasses. Her psychiatric evaluation and her adult assessment show that she was admitted for suicidal ideation. It was documented that the patient was on 15 minute checks on a special observation flow record from 3:45 pm on 9/26/08 to 10:30 am on 9/27/08. There were about 76 observations documented.

CONCLUSION

THE PAVILION Adult Unit Family Handbook, pg. 3.(2008). *You may use your own hygiene items if requested. These items will need to be checked by staff for safety purposes and will be your responsibility when these items are in your room.*

THE PAVILION Adult Unit Family Handbook, pg 5.(2008). *Due to safety measures that take place on the adult unit, staff will be doing room checks twice (2) a day.*

The hospital's housekeeping policy, which went into effect as of 12/29/08, instructs housekeeping staff to adequately clean patient rooms daily which includes collecting trash, vacuuming rooms, washing night stands, lamps, lights, chairs, and wet mopping floors. This policy would have prevented the findings in regards to complaint #1 which happened before this policy went into effect**.**

According to the Administrative Code for hospitals, *The entire facility… shall be maintained in good repair, clean and free of insects, rodents and trash. ... After the discharge of a patient, the*

bed, bedding, and room furnishings used by such patient shall be thoroughly cleaned. (77 Ill. Admin. Code 250.1710).
Under the Mental Health Code, recipients must be provided with adequate and humane care and services, pursuant to individual services plans (405 ILCS 5/2-102). Adequate and humane care and services are defined in Section 5/1-101.2 as,

…services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others.

The Code also states, *Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property…. Possession and use of certain classes of property may be restricted…when necessary to protect the recipient or others from harm….* (405 ILCS 5/2-104).

If this patient, who was very depressed with suicidal ideation, was observed 76 times (documented on the special observation flow records) it would seem probable that one of the observers should have provided her contacts case, contact solution and toilet paper. Housekeeping should have been called to clean the room. The psychiatrist was in her room **once** and could observe that the patient was in an unclean room, with no toilet paper during the time of these 15 minute observations. These events led to the patient requesting from the psychiatrist an early discharge and not receiving the mental health services that he had prescribed through this unit. Her psychiatrist had recommended at her admission that her stay be four to five days per the record. She was discharged in less than 24 hours. Per the Pavilion's Patient's Bill of Rights (2008) # 6: *You have the right to be treated with dignity and respect in the provision of all care and treatment. You have the right to privacy in your care and fulfillment of your personal needs.*

Complaint # 1. A recipient was admitted to a room that had not yet been cleaned. There is clear and convincing evidence per the record that allegation #1 has been substantiated and the following rights were violated: Mental Health Code requirements (405 ILCS 5/2-102) in regards to *adequate and humane care and services in the least restrictive environment* and the Illinois Administrative Code (77 ADC 250.1710 d).
Recommendation:

1. Follow the Mental Health code requirements and provide "adequate and humane care." When staff complete these"15" minute observations, check what is going on with the patients. Ensure that recipient rooms are cleaned and that adequate hygiene supplies are always provided.

Complaint #3 A recipient was not able to access needed personal belongings. Per the record, the HRA substantiate allegation #3, that a recipient was not able to access needed personal belongings. Per the Mental Health Code. (405 ILCS 5/2-104). *Every patient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property.*
Recommendation:

1. Follow the Mental Health Code requirements and ensure that recipient belongings that are not considered contraband are always available for use. Both the patient's contacts case and contact solution should have been permitted and brought to her when she requested, thus insuring a reasonable accommodation for the patient's vision impairment.

Suggestion:
Regarding the patient's access to meals, it appears that breakfast was provided. THE PAVILION Adult Unit Family Handbook (2008) was not very clear that a patient would have to obtain the tray from the rack herself. The HRA does acknowledge per the nurse's notes she was not communicating with staff but had curled up in a fetal position and was nonresponsive. Communication between staff and the patient appears to have been very difficult.

Complaint # 2 A recipient did not receive needed medication

Interviews
We discussed the dispensing of medications with the Director of Performance Improvements/Risk Management and the Director of Nursing. We were informed that medications are usually given at 9:00 pm but could get delayed due to processing numerous patients and due to the receipt and processing of physicians' orders.

Record Review
THE PAVILION Adult Unit Family Handbook (2008) notes a scheduled time to administer medications (9:00 p.m.) but also states that medication administration times may vary per physicians' orders. Records also show that the patient had signed a consent for the drugs that would be administered during her stay at the Pavilion. The psychiatric evaluation completed before admission to the behavioral health unit has the following medications that were prescribed for the patient: Lithium Carbonate 600 mg b.i.d., Mirtapine 15 mg nightly, Lamictal 200 mg b.i.d., Ranitidine 150 mg nightly, and Dicyclomine 10 mg daily p.r.n. The record shows that medications were given at 9:00 pm per policy and the two that were to be taken again in the morning were signed off by the nurse as having been given at 7:00am.

CONCLUSION

Per Hospital Policy #61 Medication Ordering, Dispensing and Administration, *all medications dispensed to nursing units will conform to State and Federal Laws, Joint Commission Standards, and standards of good patient care.*

The Mental Health Code (405 ILCS 5/2-102) states (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. 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.*

It appears that the behavioral health unit for adults is following medication administration policy and the Mental Health Code.

From the information that is available regarding complaint #2, a recipient did not receive needed medication, the HRA finds this complaint unsubstantiated.

Complaints #4, & #6, a recipient's private telephone communication was impeded, and facility staff behaved unprofessionally.

Interviews
Hospital representatives explained that there should not be an issue with the use of the phone; it is cordless and patients may take the phone into their rooms to make unimpeded phone calls. The HRA was shown the phone when we visited the unit. They also made the HRA aware of the patient advocate hotlines posted in the unit, which was actually accessed by the patient's husband.

We could not interview the nurse named in the complaint because this individual no longer works for the Pavilion. We discussed the issue but there was no record of any incidents recorded between the nurse and the patient. The nurse had attended service excellence training so that she should have been aware of expected professional behavior. Our observations found unit staff behaving professionally and interacting appropriately with patients and one another.

Record Review
Per the record, the nurse who assisted in the safety assessment of the patient when she was first admitted at around 2:30 pm on [redacted]; she also completed the first two and half hours of observation checks from 4:00 pm to 6:30 pm on [redacted]. Per the complaint this same nurse reportedly made a derogatory remark about her schedule and her supervisor. The complaint also stated that this nurse listened in on the patient's phone call, and did not allow the patient to have unimpeded phone conversation with her husband and would only allow her to talk for five minutes.

CONCLUSION

THE PAVILION Adult Unit Family Handbook (2008) provides specific hours that visitors may be seen. Per the handbook there were no visiting hours on Monday, Wednesday, and Fridays. The day of the recipient's admission (09-26-08) was on a Friday.

The Pavilion Patient Bill of Rights based on Chapter 2 of the Mental Health Code, Right #16 states: *You have the right to communicate with other people in private, with out obstruction or censorship by the staff at the facility. This right includes mail, telephone calls, and visits. Any limitation to these rights are outlined in our medical record and/or explained in the client handbook.* Regarding the complaint about unprofessionalism, the Pavilion Patient Bill of Rights states: *You have the right to be treated with dignity and respect in provision of all care and treatment.*

The Code (405 ILCS 5/ 2-103) states: *Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation.* Although the HRA does not discount these claims, from visiting the unit and interviewing the

staff it does appear that patient should have been able to make unimpeded phone calls, and there is no evidence to support the complaint that she could not. As far as unprofessional behavior by a staff member, the HRA also cannot substantiate the complaint due to the lack of evidence. **Per review of the record and the interview with Pavilion staff, the HRA cannot substantiate the allegation that a recipient's private telephone communication was impeded or that facility staff behaved unprofessionally**.

Suggestion:
Periodically review professional conduct and communication rights with all staff members.

Complaint #5. The facility did not complete needed medical tests.

Interviews:
Representatives explained that the facility staff attempted to complete the blood draw but the patient would not allow it. It was stated that blood level tests are taken before breakfast which would have been appropriate for the tests that the physician prescribed.

Record Review:
The psychiatrist's notes show that the patient refused to allow the blood draws when they were offered to her and would not communicate with staff other than the physician. The Pavilion's Adult unit did not violate the patient's rights further by forcing her to submit to having blood drawn for tests ordered by her psychiatrist. There is further documentation by nursing staff that the patient would not communicate with them. The HRA agrees that tests should not have been forced upon the patient.

CONCLUSION

Section 408 ILCS 5/2-102 (a) of the Mental Health Code states *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 record verified that tests were ordered, but it was the patient's decision not to complete the needed medical tests. **From the information that is available regarding complaint #5, the HRA finds this complaint unsubstantiated**.

The HRA acknowledges the full cooperation of the hospital and its staff during the course of its investigation.

RESPONSE

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

The Pavilion
BEHAVIORAL HEALTH SYSTEM

December 23, 2009

Cathy Wolf, HRA Coordinator
Guardianship & Advocacy Commission
423 South Murray Rd.
Rantoul, IL 61866-2125

Re: HRA Case #09-060-9005

Dear Ms. Wolf,

We are in receipt of a letter and findings, dated November 25, 2009, from the East Central Regional HRA.

In response to recommendations for complaint #1, our facility implemented a policy in December 2008 that formalized the expectation that housekeeping staff will clean patient rooms on a daily basis. This policy was implemented after the complaint. Rooms that are vacant are now checked and cleaned daily, to ensure new admissions are entering a recently cleaned room. Staff re-education has since taken place.

With regard to recommendations for complaint #3, all patients are allowed to access and utilize personal items that are not considered contraband. Appropriate and inappropriate personal items are outlined in both the patient handbook and in facility policy. Belongings are stored in an area that is easily accessible by staff. Staff re-education has been provided.

Thank you for your time and attention to this matter. The feedback and additional suggestions provided by HRA is appreciated and will be utilized in our continuous improvement efforts.

Should you have any questions or need additional information, please feel free to contact me at 217-373-1758.

Sincerely,

Regina Harrington, MSEd/DPIRM

Regina Harrington, M.S.E.d
Director of Performance Improvement
and Risk Management