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REPORT OF FINDINGS
PROVENA SAINT JOSEPH MEDICAL CENTER — 11-040-9011
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority did substantiate the complaint as presented; the public record on this case is recorded below. The provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission has completed its investigation into an allegation concerning Provena Saint Joseph Medical Center. This general hospital located in Joliet has an adult and adolescent psychiatric unit. The complaint alleged that a recipient was physically attacked by a peer while sleeping in his bed. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 and 5/2-112) and the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Conditions of Participation for Hospitals (42 CFR 482.13).

METHODOLOGY

To pursue the complaint, the hospital's Counsel, the Director of Risk Management, the Director of Behavioral Health, a Registered Nurse, a Mental Health Assistant and a Certified Nursing Assistant were interviewed. The recipient's record was reviewed with written consent. Relevant hospital policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the recipient was awakened when a male peer came into his room and started beating him. It was reported that the recipient filed a police report on that same night. His eyes were reportedly blackened and face was swollen for about three weeks after the incident.

FINDINGS

According to the record, the adult recipient was involuntarily admitted to the hospital's behavioral health unit because of increased paranoia on January 7th, 2011. The admitting orders indicated that he was placed on close observation for suicide and violence precautions. He was

diagnosed with Schizophrenia, Paranoid Type with Acute Exacerbation. He signed a Voluntary Application on that next day. The record documented that he agreed to take Haldol, Geodon and Ativan and that medication information was provided. He was compliant with his medication regiment and was not a management problem on the unit. The Observation Records indicated that he was monitored every fifteen minutes during his hospital's stay.

An Incident Report documented that the recipient was physically abused by a peer on January 11th, 2011. The report included statements from staff members, the recipient and his peer concerning the incident. According to a Mental Health Assistant (MHA), the recipient's peer had presented to the nursing station around 12:30 a.m. on that same morning. She reportedly gave him a gown as requested and walked him partially back to his room. She said that the recipient's peer might have followed her down the hallway and hidden in or near the electrical closet across from the recipient's room prior to the incident. She said that she was putting paperwork in the bins at the nursing station when sitter A called "Code White" (the hospital's code that notifies all staff and security personnel that there is a disturbance on the unit and Crisis Prevention techniques are implemented).

According to the incident report, sitter A was in the room when the incident occurred. The staff told the HRA that the sitter is a Certified Nursing Assistant who was assigned to monitor the recipient's roommate. Sitter A said that the recipient was sleeping when his peer entered the room at 12:55 a.m. His peer reportedly jumped on top of the recipient and started punching him on his head. The sitter ran out of the room to the nursing station yelling "Code White." There were two nurses at the desk on the incident morning, and one of them also called "Code White" when they heard the sitter yelling for help. They ran to the recipient's room to break up the fight. Sitter B who was assigned to monitor another patient in a different room came out of the room to see what was happening. He was relieved of his assignment to help break up the altercation and began pulling the peer off top of the recipient upon entering the room. The MHA reportedly did rounds (safety checks) on patients when she heard sitter A shouting for assistance.

According to the incident report, the recipient's peer alleged that the recipient had made some unsolicited sexual advances toward him leading up to the incident. He claimed that the recipient came in his room and "touched" him on the buttock right before the incident happened. He reportedly chased the recipient who managed to get back to his room and in bed before he could catch him. He said that he leaped on the recipient and started punching him on his head. He claimed that the recipient had said "I might want to [expletive] you in your behind" and had threatened him on that previous evening. According to the report, the recipient denied being familiar with his peer. He said that he had refused to play chess with him on the evening of the incident. He recalled being awakened by his peer who was on top of him and beating him. The recipient filed a report with the local police department on the 11th. The HRA noticed that a Risk Management Worksheet recorded that the recipient's peer alleged that he was "slapped" on his buttock and that the recipient had made racial remarks.

Nursing entries indicated that the physician and other administrative staff members were promptly notified. The recipient was seen in the hospital's Emergency Department because of lacerations and bruising to his face, forehead, nose and cheek bones. A Computed Tomography

Scan and X-rays of the recipient's head, arms and face reportedly showed no acute trauma or fractures. On that same morning, the recipient was transferred to another unit for his safety and was seen by the physician. A nurse later wrote that the recipient was upset because people were saying that he had touched his peer and that he said "I did [not] touch him at all." On the 12th, the recipient signed a request for discharge form and told the physician that his vision was "blurry." Two days later, the physician noted that the recipient had more discoloring around his eyes but denied having any problems with his vision. According to the record, the recipient was discharged on January 17th, 2011.

When the complaint was discussed with the hospital's staff, the HRA was informed that unit is a long hallway divided by a door. On the incident day, the recipient and his peer were assigned to different rooms on the same unit. According to the MHA, a nurse gave the recipient's peer a bottle of water at the nursing station prior to the incident. Then, she walked him back to his room and observed him go into the room. She said that she was walking back to the nursing station when she heard the sitter yelling about the patients fighting. This conflicted with her statement in the incident report that she gave the recipient's peer a gown and walked him partially back to his room. Sitter A explained that he was sitting in a chair at the foot of the bed and was facing the recipient's roommate when the incident occurred. He reported that the recipient was sleeping in his bed located near the door and did not leave the room as his peer later alleged. According to the sitter, he heard the noise in the room before he could determine what was happening because the lights are dimmed at night. The nurse reported that she pushed the panic button located underneath the desk at the nursing station when she heard sitter A yelling that they were fighting. The MHA also called "Code White" because she was unaware that the nurse had already pressed the panic button.

According to the nurse, she called sitter B to help with the situation and both of them entered the recipient's room at the same time. She reportedly saw the recipient's peer punch him on the head one time. She grabbed his peer's hand, and he stopped hitting the recipient as directed. The investigation team was informed that sitter B stayed with the peer after the altercation. The recipient's peer was acutely psychotic and he had been checked on minutes before the incident occurred. He reportedly was not on special precautions prior to the 11th, but a sitter was ordered for the remainder of his hospital's stay after the incident. The recipient was moved to the day room, which was locked for his safety, and his wounds were treated. The nurse explained that the recipient was transferred to another unit for patients with less severe symptoms because the staff believed that he could manage better than his peer on the new unit. The investigation team was informed that patients assigned to different units do not attend the same group therapy sessions or interact with each other.

According to the staff, patients are routinely checked on every fifteen minutes, and they are monitored by one or two staff members (MHAs) from the hallways. There was reportedly only one MHA assigned to monitor both hallways on the incident night. The unit staff did not have panic alarms on them because there might have been a shortage of the devices. The Director of Behavioral Health explained that the staff inadvertently take the panic alarms home because they carry the devices in their pockets. She said that the hospital is considering getting phones that would operate similar to panic alarms, but they would be larger to prevent the staff

from taking them off the unit. The Director of Risk Management reported that the recipient did not file a written grievance with the hospital.

Provena's "Documentation System" policy states that nursing must ensure that a treatment plan is written for each patient after the initial assessments have been completed. Each discipline is responsible for adding problems to the plan, and goals and interventions for existing problems.

According to the hospital's "Patient Safety Check" policy, room checks and checks to account for patients' whereabouts are routinely done. The staff are required to make rounds on patients every 15 minutes, and this information should be documented on the Mental Health Observation Record if the patient is on precaution status. The staff must have observed the patient directly when documenting the above information. The staff person must notify the Charge Nurse if he or she is unable to complete rounds. To ensure that rounds are completed, the Charge Nurse is responsible for auditing this procedure. The policy states that the staff on the unit must carry a panic alarm on them at all times for their safety. The staff should check all rooms during the first half on each shift. The policy includes procedures for making other environmental rounds such as checking all closets and hallway doors to ensure that they are locked.

The staff interviewed reported that the hospital's Behavioral Health unit does not have another policy concerning patients' safety, but that procedures are in place such as ongoing assessments of their symptoms, physical demeanor, interactions with others, etc. The hospital's Counsel said that sometimes it is difficult to have specific policy for every unit.

Provena's "Patient Grievance/Complaints" policy states that the hospital must have a process in place to document, resolve, track and trend patient's complaints and grievances. It directs all employees to accept complaints from patients or others on behalf of patients. The receiving employee will utilize the Service Recovery Process as follows: 1) Acknowledge and document receipt of the complaint, 2) Apologize to the complainant, and, 3) Provide resolution to the complaint. A member of the facility leadership team must be contacted, if the complainant is not satisfied with the resolution provided by the receiving staff person. The leadership representative must assess the complaint severity and determine if the above steps can be repeated for resolution. If the complainant continues to be unsatisfied, the complaint must be considered a grievance, and the grievance process will be initiated. The policy states that the hospital's Risk Management Department must be notified about any grievance that might be considered a variance or unexpected event.

CONCLUSION

> 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, and shall be free from abuse and neglect. (405 ILCS 5/2-102 [a] and 5/2-112). Abuse is defined in Section 5/1-101.1 as any physical injury, sexual abuse,

or mental injury inflicted on a recipient of services other than by accidental means.

According to CMS' Conditions of Participation for Hospitals Section 482.13, the hospital must establish a process for prompt resolution of grievances, including written notification on steps taken to review the matter, results, and contact information, which are also provided for in Provena's Patient Grievance/Complaints policy.

The Authority substantiates the complaint that a recipient was physically attacked by a peer while sleeping in his bed. The HRA understands that the recipient sustained physical injuries and that the incident was emotionally harmful, but the investigation team could not determine how the peer was able to enter the recipient's room without the hallway monitor seeing him and because of conflicting statements from the Mental Health Assistant. The staff interviewed reported that the recipient's peer was not on special precautions before the incident occurred. The investigation revealed that the hospital took steps immediately to provide the recipient with a safer environment after the incident. He was reportedly moved to a different unit, and his peer was assigned a 1:1 sitter for the remainder of his hospital's stay. The recipient's record indicated that supervision was provided in accordance to the recipient's services plan, pursuant to Section 5/2-102 (a) of the Code. The Director of Risk Management reported that the recipient did not file a written grievance with the hospital. No violations of CMS' Conditions of Participation for Hospitals Section 482.13 or the facility's grievance policy were found.

The hospital violates its "Patient Safety Check" policy stating that the staff must carry a panic alarm with them at all times. The Director of Behavioral Health reported that there is a shortage of panic alarms because staff members inadvertently take them home, and that the hospital might buy larger devices to prevent this. The Authority is very concerned because the hospital had not purchased additional panic alarms or developed a system such as signing in and out the devices to ensure that they are available on the unit. We noticed that the policy states that the panic alarms are for the safety of the staff, but we believe that the devices should also be carried for the patients' safety because a lot can happen in a few minutes as indicated in this case.

RECOMMENDATIONS

1. Provena shall follow its "Patient Safety Check" policy and ensure that the unit staff have panic alarms on them at all times and that environmental rounds are completed.

2. The hospital shall instruct all appropriate staff members about the importance of ensuring that recommendation #1 is followed.

SUGGESTIONS

1. The hospital might consider having the staff sign the safety devices in and out on each shift and develop a checklist for environmental rounds.

2. The Authority suggests that Provena's administration review this report with its quality assurance board because of the discrepancy in the Mental Health Assistant's statements to determine how the recipient's peer was able to enter the recipient's room if the hallways are monitored.