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East Central Regional Human Rights Authority
Report of Findings
Case 14-060-9011
The Pavilion

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

Complaints:

1. **A patient at a mental health hospital was denied the use of a wheel chair during a seizure, which caused an injury.**

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), Department of Public Health, Subchapter B. Hospital and Ambulatory Care Facilities, Special Medical Record Requirements for Psychiatric Hospitals, 77 IL ADC 250.2290 and the Code of Federal Regulations, Title 42. Public Health, Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services section 482.13.

INVESTIGATIVE INFORMATION

The HRA proceeded with the investigation having received written authorization from the patient to review her record. The HRA visited the facility, where the hospital and behavioral health representatives were interviewed. Relevant practices, policies and sections of the patient's record were reviewed.

Interviews

The HRA asked what types of services are provided. The Pavilion provides inpatient mental health services, residential treatment and addictions programs. There are approximately 103 beds, a 69-bed inpatient section and 34 residential. The staff to patient ratio is 4 to 1. The average length of stay for most patients is about 10 days. They serve all ages including children. The geographical area served is mostly downstate Illinois, but the Pavilion has had patients come from as far away as East St. Louis, Chicago, Rockford and Eastern Indiana

When asked what is the policy for patients accessing rights information, staff stated that at admission patients are provided a copy of their rights and they are explained to them. The rights are also posted in the facility. Recipients and their families are informed of the policies through the patient handbook provided at admission. They also provide patients copies of any

documents that they sign. Health Insurance Portability and Accountability Act (HIPAA) information is posted and provided at admission.

The HRA asked how treatment would be determined for the patient. Staff explained that at intake a registered nurse completes an assessment and a social worker completes a psychosocial assessment. A medical physician and a psychiatrist also assess the patient.

The treatment plan for this individual began as an emergency admission because of suicidal ideation with a plan and aggressive behavior. Her admitting diagnoses were Major Depressive Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder and Multiple Sclerosis. There was no history documented of a seizure disorder and no reference in her chart of any history of seizures. She was assessed as a fall risk due to leg pain. The patient was provided a wheelchair and was given instructions on how to use it. From observation by staff she did use the chair. The physician and the psychiatrist were responsible for overseeing her treatment. Staff stated there was no seizure or injury documented in her chart or observed.

The HRA asked what quality assurance measures the agency uses. The response was that there is a patient advisory line that is monitored by the nurse manager. A response is provided within 24 hours. At discharge, every patient is given a patient satisfaction survey. The staff are to have each patient complete a survey before he/she leaves. The surveys are monitored monthly. Staff will meet and review survey responses to determine ways to improve services. They examine verbatim statements and pass on comments regarding the need for improvement, as well as compliments pertaining to direct care staff. The hospital is Joint Commission accredited.

The HRA asked how do staff keep apprised of treatment ideas and evidenced based treatment. It was explained that at hire staff attend a 5 day training program which includes patient rights training, HIPPA protocol, hands on training, therapeutic crisis intervention and nurse specific competency training.

The HRA was provided a tour of the unit where the patient had stayed. The HRA viewed patient rooms, patient activity areas and therapy rooms. Of note, there is a new addition of a sensory room for patients to relax, decompress, and find peace. According to Sensory-processing-disorder.com, http://www.sensory-processing-disorder.com/sensory-room.html, a sensory room can be very therapeutic for an individual with a disability. By stimulating a person with activities engaging the different senses, time in this environment can assist someone with a sensory processing disorder. The Sensory Connection Problem, a website available at http://www.sensoryconnectionprogram.com/sensory_room.php, also outlines that time in these spaces can also assist an individual with stress management through guided activities.

Records Reviews

Per the record from the transferring hospital, on 5/31/14, the patient was admitted to a hospital with panic attacks and suicidal ideation. The individual was assessed by a crisis counselor and was discharged the same day. On 6/1/14, the patient was brought into the emergency department at the medical center by order of the police. There was a call made by neighbors to the police department that they heard a disturbance coming from the individual's

residence. The patient claimed that she intended to commit suicide by overdosing on the medications she stockpiles at her home. The doctor noted that it would be beneficial for the patient to be transferred to a mental health hospital for immediate services.

The record from the Pavilion shows the patient was admitted on 6/1/14 for suicidal ideation with a plan to crash her car or overdose on medication. On 6/2/14, rights were discussed with the patient per the patient's signature. Per the comprehensive assessment completed by the crisis worker, the patient was evaluated for suicidal ideation and self-harm. As part of the admission process, the patient was assessed for treatment, which included the risk of falling. Per the *Fall Risk Assessment* it was documented that the patient walks with assistive devices, including a cane and a walker. It was not checked at that time she would need the use of a wheel chair. This was based on the interview completed with the patient. Per the nurse's documentation, the patient did not receive a fall risk classification until 6/3/14, when she was marked as "No Fall Risk" with the notation "The patient correctly listed as no fall risk… due to reports of pain & numbness in leg [we] will reevaluate this."

Per the *Adult Nursing Assessment* completed by the registered nurse at admission, there was documentation that the patient had been provided orientation of the facility and environment, her room, schedules of the facility, the telephone policy, and primary nursing services. There were assessments for patient education, preferred method of intervention, self-care, discharge needs, personal history, family history, review of systems and history, chemical use history, psychoactive needs, vital signs, nutritional needs, pain assessment, patient's needs and goals for treatment.

It was documented in the personal history that the patient has Multiple Sclerosis and Fibromyalgia. Under the fall risk assessment it was documented that the patient had a behavior disorder, a history of falls, decreased coordination/loss of balance/shuffles, decreased muscular strength/weakness, poor vision with corrective "contacts", and takes mood-stabilizing medication. She scored 12 on the fall assessment document. Per the documentation if the patient had scored 20 or greater the hospital would implement a fall risk treatment plan.

The documentation shows that 29 out of 37 staff signed the patient's signature log for providing care. The occupations of the staff members included physicians, nurses, case managers, and mental health therapists. Regarding the patient's *Master Treatment Plan Goal Sheet*, it was documented that the individual would "identify triggers of her labile mood, suicidal ideations, and aggression" through individual therapy and group sessions. Her second goal was to "identify coping skills that will help her to manage her symptoms." This would be accomplished, per the *Master Treatment Plan Goal* sheet, with group sessions, individual counseling, recreational therapy, case management, and psychiatric appointments. It was also listed that the original optimal discharge date was to be 6/7/14.

At 11:00 am on 6/3/14, the patient requested a walker because her Multiple Sclerosis had affected her legs. The case manager who received the request stated that she would "present this concern to medical staff." It was documented the case manager would discuss this request with a registered nurse, who would reportedly consult the patient on the subject.

Per the progress notes on 6/3/14 at 1:00 pm, the staff heard the patient crying for help from her room. The patient had asked about the status of the walker she requested and when the staff member left to inquire about the nurse's decision, the patient yelled out. When staff returned to the patient's room, she was on the floor of her bathroom, leaning against the wall with her head by the toilet. According to the patient, she hit her head on the toilet because the staff refused to assist her. Upon examination by the nurse, there was no visible injury on the patient's head or on her back, which is another area the patient said was hurt in the fall per the nurse's progress notes.

Nurse progress notes continue to document that after staff and the patient discussed the matter, it was decided that a walker could only increase the risk of falling for the patient. On 6/3/14, the individual was provided with a wheelchair and was also taught how to operate the device safely. The next day, 6/4/14, the patient reported she had no pain. According to the nurse's progress notes, the patient was now listed as a "Fall Risk." The patient stated her legs "do not work." Additionally, the patient required assistance from staff in and out of bed because she could not tolerate when weight was placed on her leg. The nurse also reported that she observed the patient "walking and running in the hallway 2 days ago."

Upon review of the nursing progress notes, the HRA observed that the patient was "verbally abusive" with whomever she would speak to on the cordless phone. Staff cited this as the reason behind placing the patient on a restricted, corded phone program on 6/3/14. The HRA did not observe any rights restrictions notice that would correlate to hinder the patient's right to a private and unimpeded phone call.

The HRA reviewed the list of medications the patient was taking, prescribed before her admittance to The Pavilion and those orders written by Pavilion staff. According to the list of medications and instructions given to the patient at the time of discharge, the individual was to take the following: Gabapentin-pain; Baclofen-muscle spasms; Seroquel-mood; Flomax-urinary retention; Topamax-mood; Cymbalta-depression; Gilenya-multiple sclerosis; Klonopin-anxiety; Depakote-mood; and Vistaril-anxiety. As described on Drugs.com http://www.drugs.com/, five of the ten medications are used for treating seizures. Additionally, Gabapentin, Baclofen, Seroquel, Flomax, Topamax, Cymbalta, Gilyena, Depakote, Klonopin, and Vistaril all list dizziness as a side effect or "less serious side effect," as stated on Drugs.com, which could contribute to a fall. All of the medications have secondary uses, the HRA would just like to note, it is of interest that the medications have the possibility of treating seizures, as well.

Policy Reviews

Per the Pavilion *Adult Unit Patient Handbook (8/2014),* the admission process begins with staff inspecting items the potential patient brought into the hospital for the safety of everyone. There is also a list of items not permitted for patients to keep during their stay at the Pavilion, like cigarette lighters or cell phones. Then, vital signs of the individual will be recorded. Finally, the patient will be given a tour of the unit ending in their room. As a part of the extended admissions process, the patient will participate in several assessments with many different staff in the first 24 hours of his/her stay. The handbook explains what the hospital will do to prevent falls. It lists a variety of actions The Pavilion may ask of the patient to maintain

safety including "…wearing non-skid slippers when out of bed, using a call bell to ring for assistance when walking or going to the bathroom, using a walker or cane to assist in walking, and/or use of a hospital bed." There is also an addendum stating, "Please inform staff of any additional measures that you feel would assist in keeping you safe from falls while at The Pavilion." The patients are also presented with a copy of the *Patient Bill of Rights (6/2014),* in accordance with the Mental Health Code. Of note, is right Number 25, "You have the right to have disabilities accommodated as required by the American With Disabilities Act."

The HRA reviewed the protocol on staff education for identifying a seizure and first aid action for a person having a seizure from the *American Heart Association, (2006) Learn and Live*, POC-46 (10/2013): "…a medical condition called epilepsy often causes seizures. But not all seizures are due to epilepsy. Seizures can also be caused by:

- Head injury
- Low blood sugar
- Heat-related injury
- Poisons

Signs of a seizure: During some types of seizures the person may:

- Lose muscle control
- Fall to the Floor
- Have jerking movements of the arms and legs and sometimes other parts of the body
- Stop responding

Most seizures will stop within a few minutes

During a seizure you should:

- **Protect the person from injury by:**
  - Moving furniture and other objects out of the person's way.
  - Placing a towel under the person's head
- Call a Code 99 overhead (this is an in-house page for medical emergency), The nurse in charge can determine the need to call 911…

DO NOT during a seizure:

- Do not hold the person down
- Do not put anything in the person's mouth

If the person bites his/her tongue during the seizure you can provide first aid for that injury AFTER the seizure stops."

The training provided to the staff states that in the case of a seizure, it is the safest practice to assist the individual to the floor and clear all furniture out of the way. Moving someone into a wheelchair is not the training the staff received, nor is it a way to ensure someone's safety.

According to The Pavilion policy as outlined in the *Adult Unit Patient Handbook,* in order to address patient grievances, there is a Patient Advocacy Line within the hospital that an individual could call while on the unit. It is free and accessible 24 hours a day. It is stated that an advocate will address the concern with the patient within 24 hours of the next business day. The number for the Illinois Guardianship and Advocacy Commission is included in the *Patient Bill of Rights* and in the Petition for Involuntary/Judicial Admission. There are other third party advocacy groups listed on the both documents.

Conclusions

1. **A patient at a mental health hospital was denied the use of a wheel chair while having a seizure, which caused an injury.**

The Mental Health Code states in 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 Code further states in section 5/2-112 "Every recipient of services in a mental health facility shall be free from abuse and neglect." The Code defines "Neglect as failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition" in section 5/1-117.1 Per the documentation there is no evidence that the patient was abused or neglected. The Code of Federal Regulations regarding participation in Medicare/Medicaid for hospitals, state in section 42 CFR 482.13: (c) (2) "The patient has the right to receive care in a safe setting." The patient was provided a wheelchair and instruction was given on safe use of the equipment. The patient demonstrated that she was able to use the chair. The protocols of the Pavilion are supported by the Get Seizure Smart (3/24/14) publication by the Centers for Disease Control and Prevention (CDC) on the web page http://www.cdc.gov/features/getseizuresmart/, The CDC recommends to "…Prevent injury by clearing the area around the person of anything hard or sharp. Ease the person to the floor and put something soft and flat, like a folded jacket, under his head." Per the medical administration record there is quite a bit of evidence based on the medication prescribed that this patient might have had a history of seizures. There was no evidence to substantiate a claim that the patient suffered a seizure under the care of The Pavilion. The HRA found no evidence to support that putting a patient in a wheelchair to prevent an injury during the seizure would have been safe or beneficial to the patient. In addition, the HRA noted that the patient's was assessed for a fall risk at admission and it was determined that she did not have a significant risk; after the fall, her status was changed to "fall risk," and she was provided with a wheelchair and assistance in and out of bed. Department of Public Health, Subchapter B. Hospital and Ambulatory Care Facilities, Special Medical Record Requirements for Psychiatric Hospitals, 77 IL ADC 250.2290 state that "Medical records must stress the psychiatric components of the patient's condition and care including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized…." "A provisional or admitting diagnosis must be made on every patient at the time of admission and include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses." The patient along with mental illness was diagnosed with multiple sclerosis and fibromyalgia at admission. Based on the evidence, the **Complaint: A patient at a mental health hospital was denied the use of a wheelchair while having a seizure, which caused an injury, is <u>unsubstantiated</u>.**

1. **The HRA strongly suggests when The Pavilion restricts patient rights (such as the corded phone program) that staff shall advise the patient that he or she has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect including third party advocacy groups.** In accordance with the *Patient Bill of Rights*, "If your rights are restricted, the facility must notify you and it will be documented in your record.

Documentation will include a plan with measurable objectives for restoring your rights that is signed by you or your parents or guardian. You, along with your parents or guardian, will receive a copy of the plan. If requested by you, a copy will be provided to one or both of the agencies listed…." Additionally, the Mental Health Code in section 405 ILCS 5/2-103 clearly states, "2-103. 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… (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect." On 6/3/14, it was documented that the patient's rights had been restricted to using only the corded phone "due to becoming very agitated on the cordless phone...."

2. **The HRA suggests documenting an explanation as to why rights were not explained at admission in the patient's file.** Per the Mental Health Code, Section 405 ILCS 5/2-200 "(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient…shall be informed orally and in writing of the rights guaranteed by this Chapter…." According to the patient's admission documentation, the Patient Bill of Rights was unsigned until 6/2/14. The patient was admitted 6/1/14.

The HRA would like to thank the Pavilion staff for their full cooperation with this investigation. The HRA commends The Pavilion for the creation of the sensory room to better enhance and improve the quality of services provided.