



FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9032
The Clayton at Lincoln Park

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission reviewed the discharge of a mental health resident that resided in The Clayton at Lincoln Park. The complaint indicated a patient was discharged without notice or guardian approval. The guardian has placement authority for the patient.

Substantiated findings would violate protections under the Specialized Mental Health Rehabilitation Administrative Code (77 Ill. Admin. Code 380) and protections under the Specialized Mental Health Rehabilitation Act of 2013 (210 ILCS 49).

The Clayton at Lincoln Park, "Clayton" or "Clayton Residential Home" is a 232-bed, private room, 24-hour residential treatment program. All the residents of the facility have mental illness diagnoses. The HRA met with the director of nursing and the clinical director. Relevant policies were reviewed as was the patient's record with proper authorization.

COMPLAINT SUMMARY

It was reported that a patient with a MI diagnosis was transferred to a hospital to stabilize a medical condition. She had been hospitalized several times during the year. It was reported that during the week of April 11, 2018 the patient was discharged from "Clayton Residential Home," without notifying the guardian until days later. Indications were that the guardian was only notified of the discharge because the patient travelled to "Clayton Residential Home" to pick up her remaining personal items.

FINDINGS

“Clayton Residential Home” Record Review

The patient reported feeling “nauseated, dizzy and weak” on April 5, 2018. The patient’s blood pressure was elevated, and she was sent to the hospital. On April 12, 2018 Clayton documented that the hospital notified them that an alternative placement was secured at a nursing home, and Clayton informed the guardian on the same date. On April 13, 2018 the patient traveled to Clayton to pick up remaining belongings. The record indicates that guardian’s on-call line was notified on this same date. Nursing notes indicate a subsequent call was made to the guardian on April 16, 2018. The subsequent call was placed due not receiving a call back from the guardian in several days.

Guardian’s Record Review

On April 11, 2018 the guardian noted that she spoke with the director of nursing at “Clayton” about a transfer to a hospital due to the patient’s non-compliance with medical orders. On this same date the guardian called that hospital and the guardian was informed by the hospital social worker that the patient required a higher level of care. The guardian concurred with hospital’s placement decision according to her documentation. On April 17, 2018 the guardian’s notes indicate “Clayton” did inform and speak with guardian about alternative placement and whereabouts.

Site Visit and Interviews

The HRA conducted a site visit to “Clayton” on August 13, 2018. The HRA interviewed the nursing director and the clinical director. During the interview the HRA asked the staff to explain the process of discharging a patient. The clinical director informed the HRA that discharge planning is ongoing and a discharge plan is typically formulated upon admission, via the individualized treatment plan. The clinical director furthered that they do not have a written form for discharge. The clinical director did mention that the discharge plan is updated as residents’ needs change and concluded that all relevant parties are notified upon discharge.

The HRA spoke at length with the nursing director about notification of discharge. The nursing director indicated that the guardian was notified several times. The nursing director further stated that the guardian was contacted again on April 16, 2018 because there was no return call from April 13, 2018.

Policy Review

The HRA conducted a policy review of the Discharge/Transition Procedures at “Clayton.” The HRA uncovered that “Clayton” has a policy on unplanned discharges that stipulates “if a consumer feels that they are not able or willing to participate in the discharge planning process

... .. The consumer signs a Release of Responsibility and a Release of Personal Belongings and the staff prepare a Discharge Summary.”

CONCLUSION

Notification of Guardian:

The facility has documentation that indicates the guardian was contacted. The guardian has notes that reflect she was made aware of the discharge and approved the transfer. The Specialized Mental Health Rehabilitation Facilities Act and Administration Code for transfer or discharge (**210 ILCS 49/3-111 and 77 Ill. Adm. Code 380.220**) do not stipulate that a type of discharge packet or document must be in writing. In this instance the facility has none and none is required. Under the Rules a resident may simply leave on request or by written consent of a guardian who, on her own notations, agreed with the hospital on a transfer arrangement. A rights violation is unsubstantiated.

SUGGESTIONS

The HRA concluded a records review and would advise the nursing staff at “Clayton” to include time stamps on nursing notes. The HRA would also propose documenting the name of the person spoken to when securing consent for treatment, admission, transfer or discharge. Essentially, taking these steps would allow for a more concise and informative record.

The HRA would also suggest creating a formal discharge summary document. The facility’s policy stipulates that a discharge summary should be completed in the event of an unplanned discharge. Although the Specialized Mental Health Rehabilitation Facilities Act and Administration Code for transfer or discharge (**210 ILCS 49/3-111 and 77 Ill. Adm. Code 380.220**) do not require a discharge packet or document, the facility’s own policy does indicate one should be completed in the event of an unplanned discharge.

Finally, the HRA would like to add that the facility should review the policy statement under unplanned discharge. There are several reasons that a patient or consumer may not be able or willing to participate in discharge planning. In this instance, and similar situations, to only require the patient to complete “release of responsibility” and not include the guardian is not sufficient. The facility still maintains obligations to follow licensure mandates and to involve any appointed guardians, applicable agents (in powers of attorneys or mental health treatment declarations) or resident-approved family members/representatives in discharge planning.