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HUMAN RIGHTS AUTHORITY-PEORIA REGION

REPORT 19-090-9002
UnityPoint Health – Methodist|Proctor

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations at UnityPoint - Methodist|Proctor in Peoria. The complaints alleged the following:

1. Inadequate discharge.
2. Inadequate safeguarding of patient's property.
3. Inadequate treatment.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Medical Patient Rights Act (410 ILCS 5/3). The behavioral health unit at UnityPoint is a sixty-seven-bed inpatient unit. The HRA visited the facility where representatives including those involved in this patient's care were interviewed. Her medical record was reviewed with proper authorization. The facility receives patients statewide, excluding Cook county and has 23 to 25 staff members which include nurses, mental health technicians, and a psychiatrist.

COMPLAINT SUMMARY

The complaint states that a resident's clothing was stolen. Allegedly, the nurses at the facility knew who stole the clothes and have been unable to contact the individual. The facility stated all that can be done is to repay the patient for the clothes, but the patient must purchase the same outfit to be reimbursed.

The allegations also state that a physician tried to discharge the patient even though the patient still felt suicidal and homicidal. The allegations state the patient cut himself in an attempt to commit suicide and a nurse said, "No matter if you cut yourself or not, you are still being discharged from the facility." Also, a friend of the patient contacted the facility and said the patient is suicidal, and a nurse reportedly brought the patient scrubs, told him to change into the scrubs, and then they would "Forget that this even happened" referring to the contact.

INTERVIEW WITH UNITYPOINT METHODIST/PROCTOR STAFF (11/14/2018

Staff stated that the patient reported that he did not feel safe. They explained that the patient was suicidal about his lost belongings because he wanted justice. They also said that he was suicidal because he did not want to be homeless and said staff had to find him a place to live. The patient wanted long-term housing, and part of that process meant he would have to be a client of a local, outpatient mental health provider. The patient was at UnityPoint previously and they scheduled an appointment with the outpatient mental health provider, but he missed the appointment. Staff explained that if a patient required a nursing home or long-term care, staff would attempt to provide but he did not meet the criteria. To receive long-term care, for example a nursing home, there would need to be age criteria met or chronic mental health issues that interfered with the patient's everyday living and self-care. Nursing homes also have pre-admission screening criteria. If a patient was diagnosed with dementia or could not be cared for in the home, they would attempt to place them in a nursing home. This process is all patient specific.

This patient was admitted for suicidal and homicidal ideation. He made comments like "I'm suicidal because I have no place to live." The staff thought he was malingering, and the symptoms were for secondary gain. They did not think the patient was suicidal and they thought the patient was really working on his depression. The patient was admitted at the facility on 7/9 and discharged on 7/27.

The patient was in a room with roommate. The roommate was discharged, and the staff accidentally gave the patient's roommate the patient's property. Staff tried to contact the patient's roommate but had issues with contacting him to return the items. Staff provided the patient the contact information for the hospital advocate and provided him clothes. The patient said he contacted the patient advocate, but they did not pay attention. The patient was concerned about losing a pair of expensive shoes. The issue was consuming the patient. It was all he would talk about and he wanted the nurse responsible to be terminated. Generally, in this type of situation, the patient would repurchase the clothes and the facility would refund the money. Because this patient was homeless, he could not afford to purchase his clothes. During the patient's care plan meeting, it was decided to purchase the patient a gift card to a shoe store that was equal to the cost of the shoes. Staff have had other patients with expensive items and they have been diligent with tracking them. There is a locked laundry room on the unit. Patients may have one or two outfits and those can be washed whenever needed. Belongings are all documented, but typically not by brand. Every patient room has locked cabinets that the belongings are placed in, but the hospital stated there was an error. There is storage in the rooms for resident items that are not on precautions. They try to send the items patients are not supposed to have home, such as razors, phones, and keys. In this case, the patient was put in a gown in the emergency department, but once in the unit, patients can obtain their clothes based on their safety level. When this patient received his clothes, he realized the shoes were missing. The patient was given unit clothes for a few days.

The units were remodeled so the patient belonging closets were taken down. Lockers were blank and, at the time of the interview, had still not been labeled. Maintenance was working on something that patients could not tear down and hurt themselves. Staff said there were no other incidents or mistakes with property. Staff explained that they never experienced something this significant and have never heard of

something like this in the past. They are starting a new belonging process and there is now a sheet, where patients sign, indicating their belongings. Staff said they did not change the policy about reimbursing the patient but now that staff know a gift card is an option, they would make the request.

The patient was voluntary and presented to the emergency department by himself stating he was suicidal. Staff explained that the patient scratched his arm with his fingernails while at the facility. A nurse documented the suicide attempt. Also, a previous patient did contact staff with concerns about discharging the patient and the physician cancelled the discharge. The contact and self-harm occurred on 7/23. When the patient was admitted, he was placed on suicide precautions and those precautions were discontinued on 7/18. The patient did not want to leave the facility but in the final discharge, he said he felt better with having the gift card. The patient was awaiting transportation when he committed self-harm which lead to the discharge cancellation. That morning the physician felt that there were no ideations but still placed him on precautions after the incident. The patient was discharged on the 27th and left with references. When the physician orders a discharge, they tell the patient and then the nurses. A recovery plan is created, and they completed a suicide rating scale. They also provide emergency contact numbers for the location the patient is travelling to and the national numbers. The clinicians meet about follow-up appointments and the physician clears them on their last day. The discharge documentation is signed by everyone.

FINDINGS (Including record review, mandates, and conclusion)

The HRA reviewed records and documents pertinent to the complaints alleged in this case.

Complaint #1 and Complaint #3 have been combined due to similarities between the complaints

Complaint #1 - Inadequate discharge & Complaint #3 - Inadequate treatment.

In a note in the patient's plan of care, dated 7/23/2018, at 7:28pm, it reads "Patient has been upset since learning that he was being discharged this evening. He became hostile with this writer after he was found scratching his wrist in his bathroom. He again threatened to leave the hospital and kill himself. He stated that no none cares up here and we are not taking care of him properly. He stated that he would have a ride to pick him up around 1800 and was told that would be fine. He was given dinner also. After dinner he stated that his ride was not here yet and requested to wait on the unit for his ride. The house supervisor called to inform this writer that a previous patient had called and expressed concern about the patient being discharged. [Patient] had also called to complain about his being discharged this evening. This RN took a phone call from administration and was told that [the psychiatrist] was putting in orders to cancel his discharge. Patient was informed by this writer and skin check was done and he was placed back into scrubs." Another note on the same day, at 12:41pm reads "Patient still endorses Suicidal thoughts if he doesn't get his clothes back. Still endorses homicidal

thoughts towards his cousin. States he is anxious because some peers 'who have been with him since the beginning' (of hospitalization) are being discharged and he is not." Another note in the plan of care, on 7/25/208 at 9:23am reads "Patient still insists he will kill himself if discharged. Writer tried to rationalize with patient that no event is worth killing someone over, that by killing himself his family would be hurt. Minimal response – 'you don't do that to family'. Pt. has bandage on right forearm where he cut himself the other day. States he did it when some staff told him he was being discharged."

In a note on 7/25/2018 at 4:52pm it reads "met with pt today. Pt reported the meds are where they are supposed to be. Pt endorsed suicidal thoughts have decreased yet present. Pt endorsed homicidal thoughts too present." In another note on that same date, there is a statement that a barrier to achieving a goal is "ongoing homicidal and suicidal thoughts, pt endorsed a murder suicide type directed at his cousin." Another note in the plan of care on 3:33pm on 7/26/2018 reads that the police were contacted as a duty to warn because of threats against specific people made by the patient. The note also stated that the facility director would have to speak with the physician about the discharge date.

The HRA reviewed the discharge summary written by the physician on 7/27/2019 which stated "I did try to discharge him, after which he caused superficial scratch on his arm (causing distress to another patient). Due to his risk of harm and continued threat of suicide/homicide I did not discharge him. We had a care conference and discussed risk management. The police had been called as a duty to warn. They have contacted the [county name] police with this warning. … We obtained an MMPI [Minnesota Multiphasic Personality Inventory] which was consistent with malingering. He has secondary gain for being here due to homelessness and pain medication seeking. We are treating pain since he has documented shoulder injury, but he does not appear in pain (in fact laying on that shoulder in his bed as I spoke to him on day of discharge). He continued to threaten to kill himself with a razor and to go kill his cousin and ex-girlfriend. Due to clear malingering behaviors and the mitigated risk with police involvement, he was discharged." It is also documented later in the discharge summary that the patient was diagnosed with malingering and in the History and Physical (H & P) it was documented that the patient has a "History of malingering." In another section of the H & P, it reads "However prior to change to epic notes predominantly diagnosed him with malingering and substance use disorder."

The plan of care, dated 7/27/2018 which is when the patient was discharged, and it reads "Recovery plan reviewed with patient. Copies of plan were given to patient and verbalizing understanding. Patient denies any suicidal ideations/homicidal ideations." Another discharge note for 7/27/2019 at 8:37am reads "met with pt today. Pt was in room lying down under covers. Pt pointed to a letter and encouraged this mhc [Mental Health Clinician] to read. Pt note revealed his suicidal thoughts, upset feelings about the hospital losing his items, shoes clothes, and no compensation for lost items. Pt was informed that the hospital has deliberated on how to manage the issues with the lost items and can anticipate to be met with a proposal for compensation. MHC was going to take letter and add to his chart for review, pt chose to hold onto the letter to hear what the proposal to be. Met with pt at 1128 am today. Pt was asked where he will be residing if with friend or shelter. Pt denied going to a shelter, pt endorsed the person whom is picking him up from the hospital will be taking him to a couple places then to a store for a razor. Pt was asked what he was implying by his statement about purchasing a razor. Pt denied he was

implying anything." At 8:35 am on 7/27/2018 there is another note in the plan of care written by the RN which reads "Pt withdrawn to self. Reports he does not understand why he is being discharged. States he continues to have suicidal and homicidal ideations. States if discharged he plans to go to the store and buy a razor with intentions of cutting his wrists. Pt did not verbalize a specific plan to harm his cousin and ex-girlfriend. States that if he had his clothes back he would no longer feel suicidal."

At 1:08 pm on 7/27/2018, a staff member provided the patient a gift card for the missing shoes and the patient stated, "Pt reports that he still has some SI at times, and we processed through that, that for some people, suicidal ideation will at times always be present, that medication will never completely eliminate that." The conversation was communicated to the physician and facility director who approved the patient discharge. In that same section, at 2:11pm it was stated that the patient was satisfied with how the hospital compensated for the lost items and "Pt denied being suicidal about that. Pt endorsed still having some suicidal thoughts and was hoping to be here till Monday. MHC informed pt that he will be discharged today. Pt queried about what he can do as he is not sure what to do." The rest of the passage discussed the patients feeling about events in his life.

The application for voluntary admission is signed by the patient and reads "If admitted, I (the individual) shall follow the rules and regulations of the facility. I understand that the facility may discharge me (the recipient) at any time that I am deemed clinically suitable for discharge." The HRA saw no documentation that a nurse said that the patient was being discharged regardless of committing self-harm or that a nurse stated to "forget this happened" regarding a friend contacting the hospital with information that the patient is still suicidal.

The HRA reviewed the facility admission and discharge policy which states "Clinical criteria are used by the ordering psychiatrist to assist in determining appropriate inpatient admission and discharge. Clinical factors will be taken into account in determining the type of admission." The policy provides general information on the usual types of admission (Admission of a Minor, Voluntary, Involuntary) and then documents the clinical criteria for admission to and discharge from the inpatient unit. In the criteria for discharge, it states that the minimum discharge criteria is "1. No significant risk for harm to self and others; and, 2. Demonstrates an ability to provide for his or her own mental health needs or the needs can be met through outside supportive care; and/or, 3. A reasonable discharge safety plan is in place; or, 4. Psychiatric or medical care would be better addressed in another setting."

The Mental Health and Developmental Disabilities Code states "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112) and "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" (405 ILCS 5/2-102). The Medical Patient Rights Act guarantees "The right of each patient to care consistent with sound nursing and medical practices" (410 ILCS 5/3). The Code also states "(a) The facility director may at any time discharge an informal, voluntary, or minor recipient who is clinically suitable for discharge" (405 ILCS 5/3-902).

Conclusion - Complaint #1 & #3

The HRA reviewed the pertinent records and policy regarding the patient discharge and treatment. During the interview, staff stated that the patient did commit self-harm and another individual did contact the hospital with concerns about the patient. This led to the patient's discharge being cancelled. The records support that claim. Also, the patient was diagnosed with malingering, which means the hospital thought the patient was exaggerating symptoms to stay at the facility longer. The HRA also saw no evidence that nursing made any inappropriate statements to the patient and the HRA also saw no evidence of the nursing staff concealing incidents with the patient, so the patient could continue being discharged. Because of this, the HRA finds the complaint **unsubstantiated** but offers the following **suggestion**:

- In the interview, it was stated the physician did not believe the patient had suicidal ideations when he committed the self-harm that led to the discharge cancellation. The HRA felt that putting the patient on suicide precautions while not actually believing the patient had suicidal ideations could be a violation of the patient's least restrictive environment afforded in 405 ILCS 5/2-102. The HRA encourages the facility to review the situation and their process for suicide precautions to assure patients are being treated in the least restrictive environment.

Complaint #2 - Inadequate safeguarding of patient's property.

In the patient's care plan, a note on the 7/19 states the patient is upset about losing the clothes and wanted to have the police contacted and the staff stated they are trying to get the clothes returned. A note from the same day indicates that he did speak with the police. Another note on that date states that the facility did contact the other patient to exchange the clothes. In another note on 7/19/2018 the patient states "'I feel like there is no hope. I am already homeless, I want my clothes. It's all piled up.'" Another note from 7/20/2018 reads "Pt. upset about having to purchase the missing items and bring receipts in for the reimbursement. Pt reported he does not have the $ for it. MHC expressed consoling thoughts to pt about the missing clothes and also informed pt that there are efforts to have the clothes back." There is a note dated 7/21/2018 at 6:19pm written by a behavioral health clinician which reads "Pt was out in the dayroom watching TV and appeared withdrawn to himself. Pt participate in group. Pt reported that he is feeling 'not so good' today, stating that his shoes and other belongings are lost. Pt stated, 'The hospital won't pay me back for my stuff unless I go out and buy it first, which is hard to do when you're homeless and have no income.' Pt stated that the situation regarding his missing belongings 'is making me feel more suicidal and making me more depressed.' Pt endorsed depression, rating it at 10 out of 10. Pt denied anxiety currently, but stated that his anxiety is usually an 8 out of 10. Pt endorses suicidal ideation, stating 'I've been trying to find a way to do it up here, but I can't think of anything. I asked for a razor to slit my wrists.' Pt asked multiple staff for a razor throughout the shift. Pt was observed laughing after asking one staff for a razor who told him he couldn't have one. Pt stated that he has been having suicidal thoughts 'every day' and 'all day.' Pt stated, 'I will have them until I get my stuff back.' Pt denied homicidal ideation, stating 'not up here.' Pt

reported that one good thing that happened today was a peer who was a previous patient on the unit came to bring him hygiene items." In another note on 7/21/2018, it reads "On assessment this morning, [Patient] continues to report homicidal ideation towards his cousin and ex-girlfriend. He additionally reports suicidal ideation due to the loss of his shoes and clothes. We discussed other ways to cope with stressors, however, [Patient] continues to report wishing his life was ended due to the loss of his shoes and clothes. If his shoes and clothes were returned, he states that he will continue to have homicidal ideation towards his cousin and ex-girlfriend."

The HRA reviewed a plan of care note on 7/24/2018 at 5:48pm which read "Pt endorsed his frustration and suicidal thoughts endorsing he will take his life and if possible on unit will do it or let go he will find a place to purchase a razor to complete. Pt endorsed his anger and resentment. Pt denies feeling like the hospital is doing anything about the lost items. Pt reported he does not want what other non staff persons did for him on their own choice. Pt reported he feels that the staff person who made this mistake be the person who compensates and not other people. Pt reported he has few things and homeless and these were his items, he purchased and wants his things back. Pt also not believing the hospital is doing anything to contact the person who has his items and putting them back." On 7/25/2018 at 9:23am, it reads "Patient states he will remain suicidal until he gets his belongings returned. 'I paid $160 for those shoes and I care about my stuff'. Casually, writer mentioned that 2 past peers/their family had given him clothes and a $100 gift card. Patient then explained that his counselor here was saying staff had given him the items. This irritated the patient. Patient made no further comments about the new items he received. Furthermore, states 'It will happen' referring to murdering his cousin."

The HRA reviewed the discharge summary written by the physician on 7/27/2019 which read "He did initially improve with the suicidal thoughts, but his shoes were accidentally given to his roommate who was discharged. Since that time, he was more depressed and suicidal. He was given clothes and gift certificates donated to him, but was unwilling to engage in hospital process for compensation. He was focused on proper justice. I have worked with administration who have been trying to accommodate his request." In the recovery plan of care, it was stated on 7/27/2018 at 8:37am that the patient was still upset about the hospital losing his items and this was the patient's day of discharge. Another note by a different staff member, at 8:35 am on 7/27/2019 reads that the patient stated he would not feel suicidal if he had his clothes back and "When asked about the gift cards and clothes he received from peers he stated 'the nurse who lost my belongings should have to pay me back.' Pt states he does not have much and treasures the things he does have." At 1:08 pm on 7/27/2018, a section stated "I told and showed him that I was providing him with a $160 gift card to the store [Shoe Store]. Pt said that he feels better knowing he has the gift card about discharge." At 2:11pm that day it was stated that "Pt reported his satisfaction with how the hospital compensated for his lost items."

The HRA reviewed the "Rights of Individuals Receiving Mental Health and Developmental Disability Services" signed by the patient. The rights state "You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others. When you are discharged, all lawful property must be returned to you." The HRA requested documentation from the facility, and although most

documentation was received, the HRA did not receive a requested inventory of the patient's belongings. The cover letter that came with the documentation stated that "there was inadequate documentation/inventory of his belongings upon his admission." A blank inventory form was provided and a copy of the facility "checklist" procedure for gathering patients' property. The policy states that the patient's basket must be packed, and the inventory sheet must be checked for belongings. The staff is also to check the cabinet for miscellaneous belongings, as well as the medication drawer and the patient's locker in their room. The patient must sign for their valuables and the patient must pack their bag in their room. When they are completed, they must bring the bag back to the front desk. Staff take the belongings to the "admit" room and any of the patient's contraband or belongings are to be removed from the "admit" room. All the belongings are to be put into a laundry basket and labeled with the patient's name. There is one more check of the belongings before the patient leaves and then another check for money or other items that might be in security. This form is signed by staff.

The facility provided a policy titled "Personal Belongings of Patients, Safekeeping of Valuables" which reads "UnityPoint Health does not assume responsibility for patient belongings that are not required for patient use, unless placed in a Valuables Envelope and kept in the designated secure area." The purpose of the policy is to "Provide guidelines for the safekeeping of patient valuables during hospitalization" and "Outline the process to follow when secured patients' belongings are left at UnityPoint Health upon discharge." The policy does state that patients are encouraged to "send home any unnecessary belongings" and that "all personal belongings except items needed for hygiene, a robe, slippers, pajama pants, watch, glasses, dentures, and hearing aids should be sent home with the family." The procedure reads "At the time of admission the patient should be advised and encouraged to send home with a relative or friend any money over $10.00, credit cards, checks, negotiable securities or jewelry. If the patient does not have any relatives or friends to take the items home or does not wish to send valuables with friends or relatives, the valuables should be inventoried on the Valuables Inventory by the admitting care provider and sealed in the Valuables Envelope (on which patient's name is printed). Behavioral Health allows $30 cash only to remain with the patient, all other items are sent for valuable storage." The patient is to sign the Valuable Authorization Form, and the care provider signs the form and seal the envelope. The Valuable Inventory List is given to the patient and they are informed of the retrieval process. The envelope and inventory list are delivered to the Patient Access Department. The policy also describes how the patients can withdraw items from the Patient Access Department and describes what is done concerning valuables left upon discharge.

In the patient handbook, there is a section regarding clothing and personal belongings which reads "We suggest keeping a limited amount of clothing (three outfits) and other personal items at the hospital. Clothing should be comfortable and washable. If the staff is going to do your laundry, clothes should be marked with your name. Marking pens can be obtained from the nursing station. Unity Point Methodist cannot be responsible for lost, misplaced, or stolen item. Please return them to the desk when not in use. Further restrictions may be imposed to ensure patient safety. Please see items list provided in this packet for monitored items that can be check out at desk."

The Mental Health and Developmental Code states "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive,

possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him" (405 ILCS 5/2-104).

Conclusion - Complaint #2

In the interview, the facility admitted to losing the patient's property and this is also well documented throughout the record. Because of this, the HRA finds the complaint **substantiated** and offers the following **recommendations:**

- The facility has a personal property policy and means for securing valuables, but in this case, the valuables were still lost. According to the facility, the inventory list was inadequate and then the HRA was told that the possessions were provided to the wrong patient. After reviewing the policy for personal belongings, the HRA determined the actions described in the interview for storing and caring for patient property do not comply with the inventory policy for the facility. The HRA was told that the patient's property was pulled from a storage that was in their room and accidentally provided to the patient's roommate. During the interview, it was also stated that patients have locked cabinets in their rooms where belongings are placed. The discharge procedure states that patients have lockers in their rooms and there are other areas where belongings could be kept. The personal belongings policy indicates that personal items are to be stored in a Patient Access department, where patients could retrieve the items. According to the explanations provided to the HRA, the facility is not following the policy for storing personal belongings. The HRA **recommends** the facility begin adhering to their own policy regarding patient belongings storage or create a new policy regarding the storage. Staff should be trained on this policy to assure that it is followed. The HRA requests evidence of the training and the updated policy, should that be what the facility determines.
- It was stated in the interview that the lockers were all blank which is what caused the issue with losing the belongings. The HRA recommends that if this is the means that the facility wants to use as their assurance that patient property is safe, then they must label the lockers and provide the HRA evidence of the update.

The HRA also offers the following **suggestions:**

- A flaw in the practice of reimbursing patients for lost property has been illustrated in this incident which is some patients may not have the money to purchase items and be reimbursed. In this case, there was an exception made but the HRA suggests the facility rule be updated since there are patients unable to follow the practice. An option should be made for patients who lack the finances to be reimbursed. Also, the HRA did not see this documented in the personal property policy. The HRA suggests documenting this practice.
- In the general information section of the personal belongings policy, it reads "all

personal belongings except items needed for hygiene, a robe, slippers, pajama pants, watch, glasses, dentures, and hearing aids should be sent home with the family." The HRA suspects that this sentence has a typo and should read that those are the items the hospital would have the patients keep. The HRA suggests the sentence be changed in the policy.

- The HRA is concerned that the policy states "UnityPoint Health does not assume responsibility for patient belongings that are not required for patient use." There could be situations when patients want items around that are comforting, therapeutic, etc. and would not necessarily be considered "for patient use." The Code states that every patient "shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space …" except when the items could cause harm (405 ILCS 5/2-104). The HRA understands that items that are not being used are to be kept in a secure area, but not assuming responsibility for property is not in compliance with patients' allowance to "possess" personal property in accordance with the Code. The HRA **strongly suggest** the facility review this statement in the policy to assure they are in compliance with the Code.

RESPONSE

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