Disability Rights OHIO

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REPORT: Problems at the Ohio Hospital for Psychiatry

Disability Rights Ohio has investigated and documented flagrant and ongoing systemic issues at the Ohio Hospital for Psychiatry (OHP), a 130-bed, private inpatient psychiatric hospital located in Franklin County. These issues include violations of essential patient safety, care and treatment standards. Based on its investigations, Disability Rights Ohio calls on the Ohio Department of Mental Health & Addiction Services (OhioMHAS) to take all available steps to prevent future risk of harm to patients.

OHP serves individuals with psychiatric diagnoses, some of whom also have developmental disabilities. Acadia Healthcare, a for-profit provider of psychiatric services in Ohio and other states, assumed ownership of OHP in 2012.

The troubling results from Disability Rights Ohio investigations that persisted at OHP despite ongoing involvement from OhioMHAS, include:

- **Substantiated allegations** of sexual and physical abuse
- **Failure to provide treatment** in a trauma-informed setting for survivors of sexual abuse
- **Failure to request basic medical records and provide appropriate care**, resulting in one case of a patient being placed on emergency life support
- **Using seclusion in an unsafe manner** and outside of licensure requirements
- **Incomplete treatment and discharge plans**, placing patients and the public at risk
- **Using hurtful, outdated and stigmatizing diagnostic language** (e.g. retarded) in patient records

From the time Acadia assumed ownership of OHP, the facility has been repeatedly cited and placed on numerous plans of correction (POCs) by the OhioMHAS for serious concerns. Plans of correction are required to correct violations of Ohio law OhioMHAS finds. Since January 2016, OhioMHAS has conducted at least 10 on-site surveys for either complaint investigations or to try to validate plans of correction.

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In a November 2017 letter from OhioMHAS to OHP, OhioMHAS noted the high amount of complaints that contributed to the numerous on-site surveys,

> *"...OhioMHAS has received more than "33 complaints related to various aspects of patient care and treatment since December 2012,* ***significantly more than any other private psychiatric inpatient unit/hospital licensed by the Department.***"

The Department's findings in this letter are consistent with Disability Rights Ohio investigation results, noting a lack of medical oversight, physical and sexual abuse, the failure to report this abuse and even OHP's inability to provide basic care to patients:

> *"Despite the Department's ongoing efforts,* ***serious issues persist related to the Hospital's ability to competently provide emergency care and treatment to patients*** *who are medically compromised or have a sudden decline in their medical condition; proper medical oversight of patients by the medical director of Hospital physician;* ***allegations of physical or sexual abuse****; and failure to notify the Department of Reportable Incidents and when notified,* ***failure to report*** *in a timely manner."*

Over the past several years, Disability Rights Ohio's investigations at OHP (trigged by complaints from patients and the public) have revealed similar concerns regarding the quality of patient care, safety, treatment, and patient rights at OHP. In 2017, Disability Rights Ohio again received complaints and completed additional investigations that included unannounced on-site visits, tours of the facility, a review of numerous program and patient records, and several interviews with patients and staff.

Disability Rights Ohio has written several complaints to OhioMHAS based on our investigations and findings urging OhioMHAS to revoke OHP's license.[1, 2, 3] The following section highlights only a few of the issues OhioMHAS and Disability Rights Ohio have uncovered at OHP.

Allegations of sexual and physical abuse inside the hospital

In April 2017, OhioMHAS conducted an investigation at OHP due to a complaint that "a male nurse locked a female patient in a room with him and sexually assaulted the patient by repeatedly asking her to lift up her gown to inspect for bruises, touching the back of her leg, and hugging her closely during the admission process. The complainant claimed that the same male nurse later entered her room and forced her to take medications that were not ordered for her." OHP removed the alleged perpetrator from the staffing schedule and later terminated him from employment.

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1 DRO letter to OhioMHAS, January 18, 2018
2 DRO letter to OhioMHAS, January 26, 2018
3 DRO letter to OhioMHAS, April 2, 2018

However, in the course of OhioMHAS's investigation, it found the following problems:

- During the alleged perpetrator's employment at OHP (5 months), **he had received two previous disciplinary actions**, including one for a previous sexual abuse allegation.
- **The alleged perpetrator was subject to a consent agreement** through the Ohio Board of Nursing: "There is no evidence that the Hospital implemented heightened monitoring/clinical supervision of this individual related to the OBN consent agreement or the initial disciplinary action, even though this was recommended on the Hospital's disciplinary action form. Leadership stated that they were unaware of the contents of his personnel file."
- "**The Hospital failed to comply with its policy titled 'Alleged Patient Neglect and Abuse by Staff**,' i.e. failing to immediately notify the physician of the alleged abuse, and completing an incident report timely. Leadership had not completed a comprehensive analysis of the allegation and admittedly was unaware of the professional history of the alleged perpetrator prior to the patient's allegation. Leadership failed to increase supervision or implement an internal monitoring process of the alleged perpetrator's clinical care and treatment following the Hospital's initial disciplinary action."
- "**The Hospital failed to submit a reportable incident of an abuse allegation to the Department within 24 hours of its discovery**, and only submitted a reportable incident 6 days after discovery following the Department's unannounced survey. The prior allegation of abuse involving the same alleged perpetrator was also not reported to the Department timely, i.e. within 24 hours of discovery."

Less than one year later, in 2018, Disability Rights Ohio received a new complaint and investigated the alleged sexual assault of a patient by non-staff at OHP. Disability Rights Ohio's investigation found similar problems to those identified by OhioMHAS in April 2017:

- OHP had knowledged the victim's history of sexual abuse, and, **nevertheless, placed the victim on a unit with another patient who was supposed to receive one-to-one supervision for "inappropriate sexual behavior.**"
- OHP received information from an outside source prior to the sexual assault that the alleged perpetrator had exposed himself to the victim, but **OHP took no action to ensure the victim's safety**.
- **After the sexual assault took place at OHP, there is no documentation of any kind of support or counseling to assist the patient with processing the trauma**. There is also no indication that OHP acknowledged the emotional and/or physical manifestation of trauma as a factor in the patient's treatment on the unit.
- **Importantly, there are no notes indicating that the clinician discussed trauma or provided any support to the patient**, though the patient had just returned from the hospital after being sexually assaulted. Instead, the clinician discusses with the patient the "importance of controlling [the patient's] violent behavior."

Disability Rights Ohio notified OhioMHAS regarding the results of its investigation and requested that OhioMHAS take the necessary steps to revoke OHP's license.

Failure to obtain necessary information regarding basic patient care

In November 2016, Disability Rights Ohio received a complaint about the treatment of an OHP patient with intellectual disabilities who was nonverbal. Upon the patient's admittance, OHP staff neglected to request her medical records, which contained critical information about her need for anti-seizure medication and a modified diet to prevent choking. Hospital staff also refused to listen to her family when they tried to provide instructions about her dietary needs and communication strategies. Ultimately, the patient was not given her needed medication, began to have seizures and eventually had to be transferred to a medical hospital, where she was placed on life support for a period of time.

Disability Rights Ohio reported its concerns regarding this incident to OhioMHAS. OhioMHAS investigated the incident and in a letter to OHP, dated January 30, 2017, stated the following:

> *"After further review and consideration…**the Department is issuing a probationary license for your inpatient units, effective today, pursuant to serious deficiencies found during the on-site survey**. These deficiencies center around inadequate nursing assessments, lack of timely physician orders, omitted necessary patient medication while hospitalized, failure to obtain ordered lab work, inadequate treatment planning resulting in patient rights violation, and failure to timely submit a reportable incident."*

To address the ongoing concern, Disability Rights Ohio wrote a letter to OhioMHAS and the Ohio Department of Developmental Disabilities (DODD) on March 16, 2018, with concerns that psychiatric hospitals have no policy or practice of requesting or receiving Individuals Service Plan (ISP) information for individuals receiving services from DODD. ISPs contain important information relevant to the individuals' history, services, and needs. This lack of information creates unsafe environments, makes staff unable to correctly identify appropriate services or create a comprehensive service/treatment plan, and puts patients at higher risk for abuse and neglect. The lack of communication about the patient's ongoing service coordination through DODD directly affects that individual's ability to receive mental health treatment. Disability Rights Ohio proposed that OhioMHAS and DODD create a mechanism to share this information between DODD and the hospital, with the consent of the individual or their guardian.

OHP's use of seclusion

Angel Piper (OHP CEO) and Sheena Crawford (OHP Director of Compliance) told Disability Rights Ohio that OHP did not have seclusion rooms and it is against hospital policy to seclude patients. However, during an on-site visit, a patient took Disability Rights Ohio to the room where patients were secluded. The room was small, and there was a single mattress with a wooden bedframe. There was a stench of urine in the room, and the patient lifted up the wooden bedframe to point out stains in the wood,

which appeared to be caused by urine. The room did not have windows, and the patient reported that the patient was left in the room for prolonged periods. As there was no way for the patient to tell time, the patient wrote the date on the wall to try to keep track of time.

Again, Disability Rights Ohio asked OhioMHAS to investigate this reported use of seclusion. In response, OhioMHAS sent a letter to OHP, dated January 25, 2018, detailing that it had conducted an on-site investigation on December 21, 2017.

OhioMHAS spoke to Ms. Piper and Ms. Crawford. **Ms. Piper stated that "locks were removed from the door of the room in question on ICU after an on-call administrator discovered a patient was secluded without a physician order on the geriatric unit in November 2017."** Ms. Piper also stated that the "hospital's restraint policy states that the hospital is seclusion free." Ms. Piper "advised that the nurse who implemented seclusion without an order in November was terminated and that staff education was provided related to the prohibition of seclusion at a skills fair in November."

OhioMHAS stated that when Ms. Piper was "questioned about the hospital's failure to submit a reportable incident related to the inappropriate seclusion in November, you stated, 'We didn't know where it would fall as a reportable incident; the patient wasn't injured and wasn't complaining."

OhioMHAS required the Ohio Hospital for Psychiatry to submit a plan of correction. "Specifically these corrective actions related to the following Department concerns about the hospital:

1. **Continued failure to submit reportable incidents or submit them timely;**
2. **Continued failure to complete H&Ps (medical history and physical examinations) timely;**
3. **Lack of a trauma informed care approach related to use of seclusion/restraint;**
4. **Lack of staff understanding related to the definition of seclusion and compliance with related hospital policies and procedures; and**
5. **Inconsistent documentation in the medical record."**

History of persistent problems related to treatment and patient discharge

OhioMHAS has consistently cited OHP for violations regarding treatment and discharge plans. Despite several plans of correction, the problems persist.

Citations issued by OhioMHAS and updated information provided to Disability Rights Ohio show a consistent, ongoing pattern of neglectful recordkeeping and care:

> On April 8, 2016, OhioMHAS issued a letter to OHP and indicated that the Director of Nursing (DON) at OHP, Rose Cowan, had informed OhioMHAS that an "Inventory Retention Task Force" was developed to ensure patients received their belongings at discharge. **Yet, when Disability Rights Ohio reviewed the discharge documentation for 443 individuals receiving inpatient psychiatric care at OHP**

between November 2017 and December 2017, 229 Discharge Plans had a blank checkbox for "all valuables have been returned to patient."

On March 6, 2017, OhioMHAS issued a letter to OHP detailing a plan of correction that included "Quality Assurance monitoring, procedural changes, and/or staff education related to timely completion and review of master treatment plans." **Yet, when Disability Rights Ohio reviewed the treatment plans of 61 individuals receiving inpatient psychiatry care at OHP between November 2017 and December 2017, several treatment plans lacked necessary information, including medication administration records, nursing sections (though some were signed by nursing), psychiatric evaluations, and patient signatures.** Additionally, several treatment plans indicated that patients were meeting with a doctor for 17-18 minutes exactly. It seems unusual for a doctor to meet with multiple patients for exactly 17-18 minutes, raising concerns that the meetings may not have been taking place or that hospital staff were merely copying and pasting identical information and not properly addressing patients' care needs.

A similar pattern was found with OHP discharge plans. Disability Rights Ohio reviewed the discharge plans of 443 individuals receiving inpatient psychiatric care at OHP between November 2017 and December 2017. Of the 443 individual discharge plans reviewed:

- **229** had a blank checkbox for "all valuables have been returned to patient";
- **165** had blank or incomplete "Recovery & Support" section;
- **135** had a blank "Discharge Medication Education" checkbox;
- **128** had a blank "other important contact information";
- **104** "Tobacco Cessation" section;
- **56** had a blank "Treatment Summary";
- **38** had a blank "Discharge Plan Review Checklist" section;
- **26** had a blank "Discharge Diagnosis";
- **19** were missing signatures;
- **6** had no scheduled after care appointment.

Using hurtful, outdated and stigmatizing diagnostic language in patient records

On March 16, 2018, Disability Rights Ohio wrote a letter to OHP stating that, **while reviewing patient records, a patient was referred to as "mentally retarded developmentally disabled" in the admission paperwork. Similar terminology was present in discharge paperwork, and one patient was referred to as "MRDD" throughout their entire file. The actual diagnosis on many of the psychiatric notes was "MRDD."** Disability Rights Ohio notified OHP that "in the Diagnostic & Statistical manual of Mental Disorders Fifth Edition (DSM-5) there is no diagnosis for 'mental

retardation'" – the term has been replaced with "intellectual and/or developmental disability." Additionally, Disability Rights Ohio requested that "the Ohio Hospital for Psychiatry immediately cease using the terms 'mentally retarded' & 'MRDD'." Disability Rights Ohio requested to be provided with a policy that addresses using stigmatizing language that is not an approved DSM-5 diagnosis. OHP responded with the requested policy, immediately ceased using that stigmatizing terminology and outdated diagnosis, and issued a statement that their staff was trained to use the terms "intellectual disability and/or developmental disability."

Conclusion

Those with psychiatric disabilities deserve to be cared for appropriately and to expect a basic level of safety while at a facility. Ohio Hospital for Psychiatry has demonstrated, over a significant period of time, an inability to provide services in a safe and effective manner. Indeed, the public would be outraged if these issues arose at a general medical center. People receiving psychiatric care deserve no less, and Disability Rights Ohio expects that Ohio's regulators will take appropriate and strong steps to ensure that patients are no longer neglected or harmed by this facility.