FACILITY - - MUST BE HUMANE

THE LAW

Each patient shall... "Have a right to a **humane... physical environment** within the hospital facilities. These facilities shall be designed to afford patients with **comfort and safety**, to **promote dignity** and **ensure privacy**. Facilities shall also be designed to make a **positive contribution** to the effective attainment of the treatment goals of the hospital."

§ 51.61(1)(m), Wis. Stats. [Emphasis added.]

"Treatment facilities shall provide patients with a **clean**, safe and **humane** environment..."

DHS 94.24(1), Wis. Admin. Code [Emphasis added.]

DECISIONS

1. An inpatient complained about **lack of interactions with staff** during her six-day stay. Each patient's needs and perceptions are unique, and staff cannot use a "one size fits all" approach. There is a thin line between respect for a patient's privacy and choices (e.g. to not have many interactions with others and to be given personal space), and going too far in the other direction (e.g., in trying to probe for interaction with many questions). In the latter instance, the patient could have complained that she was not respected and not given reasonable space or privacy. Here, the record reflects a **reasonable degree of staff attentiveness** and vigilance and, in the latter part of the stay, more discussion with her about issues. It was concluded that the patient's right to a humane psychological and physical environment was **not violated** in this circumstance. (Level III decision in Case No. 99-SGE-08 on 3/23/01.)

2. The individual's **right to treatment** includes specific **protocols** as necessary to **ensure health and sanitary living conditions**. The treatment needs of the client need to be considered and clearly documented in the contract between the county and any contract agencies, with a plan for monitoring and updating those treatment goals. Any barriers to achieving these needs must be documented, the guardian must be informed, and a plan to resolve such issues needs to be implemented. These **treatment protocols** are an **essential feature** for the treatment and management of the client, and they are an **integral part of the client's right to prompt and adequate treatment**. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

3. The sister/guardian of a woman filed a grievance about the **care** the woman had received while she was **living in her own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The guardian alleged "abuse of a vulnerable adult" because the woman's apartment was not kept clean by the contractor and was "unlivable due to filth". The contract contained no specific requirements, but there was a list of duties for

the staff who visited her apartment. One duty was to clean the apartment weekly. During one particular period, the contractor's employees did not complete many of the required items and the apartment became very dirty. Instead, they spent the time **providing companionship** to the woman. Regardless of her desire for companionship, the **employees were responsible** for keeping the **apartment clean**. Whenever possible the caregivers should be making sure the task list is completed while working with the client to model those skills, and to create a social situation where tasks can be completed together and in a way that is therapeutic for her by reinforcing daily living skills. The **contractor violated** her right to a **humane environment**. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

4. The **county** is **ultimately responsible** for the **health and safety** of a client to whom they provide services. Even though they have a **contract** for an **independent service provider** to do the hands-on services, the **contracted agency's failure** to perform its duties **is also the county's failure**. The county must monitor the providers it contracts with in order to ensure that vital services are provided for their clients. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

5. A patient complained about the manner in which facility staff treated her **during an Emergency Detention**. She focused her complaint on staff shining laser-pointers and lights in her eyes, especially at night. **Patients on ED require frequent monitoring** as they are usually in a crisis situation. That means **staff must continuously check on their welfare, even at night**. In the dark, it requires shining a light on them to make sure they are OK. Lights are also used by clinical staff to check the patient's eyes for dilation. While **this can be very irritating** to the patient, it is **often necessary** for their welfare. There is insufficient evidence to conclude that a laser pointer was used on her. It could also have been a small, focused light. The blurred vision she experienced could have been caused by many different factors, including the stress or her ED and medications she may have taken. No rights violations were established. (Level IV decision in Case No. 08-SGE-01 on 7/23/08)

6. A patient claimed that her right to a humane environment was violated when a strip search was conducted without warning upon her admission to an inpatient psychiatric hospital. The **relevant administrative code provides in part that searches should be done in the least intrusive manner possible. The least intrusive manner possible means that the patient should have an unhurried chance to understand and agree to the search before it begins.** Specifically, the reasons for the search should be conveyed before the search, and the patient should be made aware of the option to refuse the search and that doing so may mean that the patient cannot receive treatment for safety or security reasons. Strip searches are allowed before a patient leaves or enters the security enclosure of maximum security units, before a patient is placed in seclusion, or where there is documented reason to believe that the patient has, on her person, objects that threaten the safety or security of patients or staff. In the case at hand, **no documentation was done by the provider staff that indicated that staff suspected that the grievant had any threatening objects on her person**. Even

though a strip search is reasonable measure to ensure the safety of staff and patients, **the fact that there was no individualized documentation of the need for a strip search is a violation of the code. A violation of the grievant's right to a humane environment was found because of the lack of documentation.** (Level III decision in Case No. 15-SGE-0008 on 6/16/2016)

7. A patient's family grieved on behalf of the patient when a caregiver drove the patient, who is non-verbal and has severe autism and epilepsy, to an unplanned, undisclosed location for personal reasons for approximately one hour. The caregiver defensively informed the family that he took the patient to the grocery store, but told the provider that he was talking with a friend while the patient stayed in the car. The provider chose to believe that the patient was in the car while the caregiver talked with a friend in the driveway, and acknowledged that this was inappropriate and unprofessional. However, the provider did not find a rights violation, as they believed that the patient was not unsupervised during that time. It cannot be determined the exact details as the caregiver's integrity is questionable. Further, the patient could have been in severe danger or subject to abuse at the undisclosed location. It was determined that the caregiver departed from professional judgement by taking a highly vulnerable individual to an unknown location for personal reasons, not having the authority to take the client to an undisclosed location, and violating rules of employment; therefore violating the patient's right to prompt and adequate treatment. Additionally, the patient's right to a safe and humane environment and to dignity and respect were violated as this put the patient in unnecessary danger and the caregiver did not consult with the guardians if this "errand" would be beneficial to the patient. (Level III Grievance Decision in Case No. 18-SGE-06)

8. A patient filed a complaint that the Individual Service Provider (ISP) providing support services as part of the patient's service plan created an unsafe environment when the ISP took phone calls during sessions and left the patient alone when moving items. Based on the best available evidence, the ISP did not create an unsafe environment for the patient. The ISP received phone calls from his Supervisor during sessions. The Service Facilitator reminded the ISP that phone calls should not be answered during sessions. Additionally, it is documented the ISP took predetermined breaks during four hour long sessions with the patient. There is no evidence to suggest the ISP left the patient in unsafe conditions. (Level III decision in Case No. 21-SGE-04)

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