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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9008
JOHN J. MADDEN MENTAL HEALTH CENTER

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at John J. Madden Mental Health Center (MMHC). It was alleged that the facility did not follow Code procedures when it ordered a search of a recipient's room and person, administered psychotropic medication to the recipient without her knowledge, and verbally abused the recipient. If substantiated, this allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Madden Mental Health Center is a 269-bed, Illinois Department of Human Services (DHS) facility located in Hines, Illinois.

To review these complaints, the HRA conducted a site visit and interviewed the Medical Director, the Chief of Psychology, the Director of Nursing, and a registered nurse involved in the recipient's care. Hospital policies were reviewed, and the recipient's clinical records were reviewed with consent.

COMPLAINT SUMMARY

The complaint alleges that the recipient had circulated a petition (10/09/09), signed by 26 residents, that a staff member had been verbally abusive to the residents on the unit. The petition and a copy of it were then removed by staff, with no action taken.

Three days later (10/12/09), the complaint alleges, the recipient received visitors and at that time she received loose tobacco and also passed some on to other residents. She was told by staff, "Hand it over or we will strip search you." Although the recipient then turned over the tobacco, she was still searched along with her room. The complaint alleges that the recipient was retaliated against for circulating the petition against staff.

The same evening at 10:00 p.m., the complaint alleges that the recipient was playing cards and she noted that the medication, which was usually administered at this time, was late. The recipient finally approached staff asking them to give her the scheduled medication. The

recipient then took the medication and recalls that within 5 minutes she could not hold her head or arms up and another resident had to carry her to her room, where she immediately fell asleep until the next morning. The complaint alleges that the recipient was given the wrong medication because of her unusual reaction.

FINDINGS

The MMHC Intake documents show that the recipient was voluntarily admitted on 10/06/09 at 6:30 p.m. after being transferred from an emergency room where she was treated for attempted suicide. Progress Notes show that over the next several days the recipient attended therapeutic groups, socialized with peers, and stabilized overall. On 10/12/09 a Nursing Note states, "Pt. had visitor during visitation, was found with a handful of tobacco wrapped in a paper towel when search was done. Pt states, 'somebody else passed it to me.' Pt. was informed about visitor restriction policy she verbalized understanding. Will continue to monitor pt. and will inform MD." The notes then indicate that the physician was informed of the incident, an order was given for restriction of visitation, and a Restriction of Rights Notice was issued.

Hospital representatives were interviewed regarding the incident. Staff reported that if they suspect that contraband has been brought in the building through visitors, then the suspected recipients are checked, as is outlined in their residents' handbook. If some type of loose contraband is discovered, such as tobacco, then the recipient, their room, and their clothing are searched (not cavity searched but stripped of their clothing). Generally, recipients would not be asked to turn over contraband on the condition that they would then not be searched, because this places all recipients and staff in danger. In this case the recipient was searched and then taken to her room where she was searched by a female staff, who asked her to remove her clothing, which was then searched. Generally an incident report would be filed, which was done in this case, and the incident report would be reviewed by the Medical Director, the Director of Nursing, Quality Improvement, and the Chief of Security during their meetings which occur 5 times weekly. Staff also stated that the policy on visitation and contraband is reviewed constantly with the residents and they sign off on this policy after they review their handbook at admission or soon thereafter.

The record contains a Psychiatric Progress Note made on 10/14/09 indicating that the recipient was seen for a psychiatric evaluation and assessment: "The pt. is asking if her visitors are restricted. The pt. is claiming that she got a medication on the WE [weekend]. The pt. is upset by the staff. The pt. is not depressed or suicidal. No HI [homicidal ideation]. She denies AH [auditory hallucinations], VH [visual hallucinations], or D [depression]. The pt. is having blurred vision for 1 wk. The pt. has been taking Ambien every night. The pt. is going to stay with her son and going to [substance abuse treatment]. She is well groomed HF [Hispanic female]. Speech is normal rate, vol and tone. Mood is good. Affect is smiling, full and congruent. Thought organization and content are logical, sequential, and goal directed. Pt. denies AH, VH, and D. No evidence of psychosis. Pt. denies SI and HI."

Hospital representatives stated that at the time of this entry they had been made aware of the residents' complaints about a staff member who was reported to have been verbally abusive with several residents. The physician in this case called the report of verbal abuse in to the Illinois Office of the Inspector General (OIG) within the 24 hour mandatory time frame, and

several other staff members also called it in. The alleged perpetrator was then placed on administrative leave pending an investigation by OIG. Hospital representatives stated that residents have several options for making complaints. There is an anonymous complaint process for filing recipient grievances, there are group meetings to address community issues and grievances, and there are notices posted in the community areas offering the numbers for the Guardianship and Advocacy Commission well as The OIG and Equip for Equality.

The record contained only one reference to medication and it is the following statement, "The pt. is claiming she got a medication on the WE…." Hospital representatives stated that the staff member who wrote this quote did not indicate that there was a problem with the recipient's medication and thus it was not reported. The Medication Administration Record indicated the recipient was given only her regularly scheduled medication, which she had consented to take since her arrival on the unit, which consisted of Celexa, 20 mg each morning, Ambien, 10 mg prn (as needed), Thiamine, 100 mg daily, and Folate, 1 mg daily. Staff were not made aware of any irregularities regarding the recipient's medications (the recipient made no complaint of adverse effects) and the recipient did not request medication outside of her regularly scheduled medication.

STATUTORY RIGHTS

The Mental Health Code states that every recipient of services shall be free from abuse and neglect (405 ILCS 5/2-112).

According to the Illinois Administrative Code (59 Ill. Admin. Code 50.20),

> [a-1] If an employee witnesses, is told of, or has reason to believe an incident of abuse or neglect or a death has occurred, the employee, or facility shall report the allegation to the Office of the Inspector General hotline according to the facility's procedures.
>
> [a-2] Within four hours after the initial discovery of an incident of alleged abuse or neglect, the required reporter shall report the allegation by phone to the OIG hotline.

The Mental Health Code states the conditions under which personal property may be restricted:

"Possession and use of certain classes of property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction is given to all recipients upon admission." (405 ILCS 5/2-104)

The Mental Health Code mandates that the administration of psychotropic medication be based upon the consent of the recipient:

"If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the

recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [an emergency], or 2-107.1 [a court order]…(405 ILCS 5/2-102)."

FACILITY POLICY

MMHC policy (Section 200 Patient Rights No. 280) states that any alleged verbal abuse by staff, along with physical, mental, or sexual abuse, as well as neglect, will be reported to OIG. The facility informs the patient, guardian, and the public of the facility policy on how to report complaints/concerns and the process of resolution.

The MMHC *Patient and Family Handbook* states that smoking is not allowed on the hospital property and grounds. It states that matches, lighters, cigarettes, etc., are not allowed on the unit and that these items will be taken from the patients if found. The Handbook urges patients to inform family members and friends that they should not bring these items into the facility. Also, any packages or bags that visitors bring are checked by nursing or security staff before they are allowed to visit.

MMHC policy (Section 200 Patient Rights) confirms the Mental Health Code right of patients to have informed consent for all medications along with the right to refuse such medications.

CONCLUSION

The complaint in this case alleged that staff was verbally abusive to recipients. This complaint was reported to the OIG by hospital staff when they received it and the staff person was then reprimanded and placed on administrative leave. The HRA feels that the appropriate authorities and the facility responded accordingly to this complaint.

The complaint also alleged that the recipient and her room were searched for cigarettes, even though she was told that if she turned it in she would not be searched. The Mental Health Code indicates that the possession of certain properties may be dangerous to all recipients and be restricted, and thus the recipient's rights were not violated. The HRA does not substantiate the complaint that the facility did not follow Code procedures when it ordered a search of the recipient's room and person, however we caution MMHC to limit the restriction of visitation rights to the individuals involved in the offense and for an appropriate period of time.

The complaint also alleged that hospital staff administered psychotropic medication to the recipient without her knowledge. The hospital record shows that the recipient received her regularly scheduled medication with consent and that she did not report adverse effects to the staff and none were noted in the progress notes. The HRA does not substantiate the complaint that the recipient was administered psychotropic medication without her knowledge.

SUGGESTION

1. The HRA suggests the hospital develop policy which outlines the procedure for body searches to include the rationale for the action and the consequences resulting from it.

2. Remember when restricting visitation rights to limit the restriction to the individuals involved in the offense and for an appropriate period of time.

RESPONSE

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

Illinois Department of Human Services

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Sept. 24, 2010

Jill Quinto, HRA Chairperson
Guardianship and Advocacy Commission
1200 S. !st Ave Box 7009
Hines, Ill. 60141

Re: HRA # 10-030-9008

This is in response to the report of the HRA investigation of case # 10-030-9008.

We would like to requests a change in the last sentence on page 2. This sentence reads "The staff member was then reprimanded and placed on administrative leave from Oct. 16 2009 through December 17, 2009." We do not reprimand staff under these circumstances until there has been an investigation and a finding against the person or persons involved. The sentence should simply read that the alleged perpetrator was placed on administrative leave pending an investigation by OIG.

We will take your suggestions concerning the restriction of visitation rights and the search policy into consideration.

Sincerely,

Robert Sharpe, MD
Medical Director
Madden Mental Health Center