HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 19-030-9003
Madden Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation due to complaints of rights violations in the treatment of a patient at Madden Mental Health Center, a state-operated hospital in Hines, IL. The complaint is that a patient was not free from abuse and neglect. The complaint further indicates that the patient reported the allegations of abuse and nothing was done.

Madden Mental Health Center is a 140 bed, Illinois Department of Human Services (IDHS) run facility. The Facility has capacity set at 100 patients and provides care to 2,300 patients annually.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS. 5).

The HRA met with hospital staff and administration to discuss the patient's care. Relevant policies were reviewed as was the patient's record with proper authorization.

COMPLAINT SUMMARY

According to the complaint, a patient reported that he was attacked by another patient while receiving care at the hospital, the complaint furthered that the patient had been previously warned about the abusive patient. The complaint asserted that the patient notified the staff and nothing else was done.

FINDINGS

"Madden Mental Health Center" Record Review

The patient was "attacked by his peer without provocation" per the nursing notes on July 8, 2018 at 3:40 P.M. The patient was transferred to a hospital the next day, July 9, 2018, via ambulance. He returned from the hospital on July 10, 2018 in stable condition however, he still complained of "soreness around the chest area." The patient was seen immediately by a nurse to follow up on

care. The patient was also seen by a social worker. The social worker noted that the patient was "in a good mood, looking forward to next week discharge." There are no other nursing notes or physician notes indicating an incident investigation or a referral to another investigative agency.

Site Visit and Interviews

The HRA conducted a site visit to Madden Mental Health Center on October 29, 2018. The HRA interviewed the nursing director, assistant nursing director, the quality control coordinator, two nurses that provided care to the patient and the hospital administrator. During the interview the HRA asked the staff to explain the process of investigating peer to peer abuse.

The quality control coordinator informed the HRA that staff receiving complaints/concerns on the unit will attempt to resolve the complaint at the unit level. The nurses, who had direct care with the patient, shared the same sentiment of the quality control coordinator. The nurses then stated, in this patient's case, a critical injury report was completed, and the patient initially refused treatment. The nurses also acknowledged that the perpetrator had a history of erratic behavior with all patients on the unit and was transferred from the facility upon this incident. Per the nurses, the patient later complained of chest pains and was sent to a hospital for evaluation.

Finally, the nurses that worked directly with the patient spoke in general terms of how they typically handle incidents of this nature. The nurses mentioned that they offer more counseling to the patient(s), consider transfers from the unit, and if the patient is injured they send the patient(s) out for treatment at a local hospital. They then follow up with the patient(s) upon returning from the hospital.

The quality control coordinator informed the HRA of the policy that all complaints or concerns about treatment and care can be brought to the attention of the Clinical Nurse Manager. The coordinator furthered that concerns about safety should be addressed immediately. The hospital administrator agreed and added that if the complaint could not be resolved at the clinical nurse manager level it would be forwarded to administration to best handle it. There was no mention of contacting the Illinois Office of Inspector General (OIG) for peer to peer abuse.

Policy Review

The HRA completed a review of the "Reporting and Resolving Complaints/Concerns" policy, and the "Incident Reporting" policy. Neither policy implicitly mention peer to peer abuse, but both of Madden's policies attempt to resolve complaints at the unit level with the involvement with the complainant and treatment team. The policies also state that any reports of staff abuse (sexual, mental or physical) will be referred to OIG.

The Mental Health and Developmental Disabilities Code stipulates when another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to

determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility.

These policies meet the standards set forth in Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112 & 405 ILCS 5/3-211) as they consider the health, safety and well-being of the complainant and the perpetrator.

CONCLUSION

Under the Mental Health and Developmental Disabilities Code, whenever abuse by another recipient is evident, his or her condition shall be evaluated to determine the most suitable therapy or placement in consideration of safety. (405 ILCS 5/3-211).

The hospital has nursing notes that recognize that the patient was involved in an altercation with a peer, to which he did not provoke. The nurses who provided direct care also insist that the patient refused treatment initially. There are nursing notes that correspond to the patient's refusal. The nurses also informed the HRA that the perpetrator was transferred from the facility.

Furthermore, the patient's record also reflects that when he did complain of soreness, he was sent out for treatment. When the patient returned from the hospital; he was seen immediately by a nurse to follow up on his care. The patient was also seen by a social worker. The social worker noted that the patient was "in a good mood, looking forward to next week discharge." The HRA concludes that while an incident of peer to peer aggression did occur, Madden assessed the situation and determined that a transfer for the aggressor was the most suitable response as required under the Code. Therefore, a rights violation is unsubstantiated based on the information available.

SUGGESTIONS

The HRA concluded a records review and would advise the nursing staff at Madden Mental Health Center to maintain penmanship on nursing notes as they are hand written. The HRA would also propose consistently documenting the title of the person completing the nursing, progress and social work note.

The HRA reviewed the "Reporting and Resolving Complaints/Concerns" policy, and the "Incident Reporting" policy. As such the HRA would suggest adding reporting peer to peer aggression to OIG to both policies. The HRA views reporting instances of peer to peer aggression (resulting in physical or mental/emotional injury) to OIG as imperative. Facility recipients exhibiting a pattern and history of repeated aggression toward peers, as referenced in this case, not only puts other recipients at risk of harm but could constitute a neglect finding as per the Code's definition of "neglect" which states that "'Neglect' means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to

a recipient or in the deterioration of a recipient's physical or mental condition.” (405 ILCS 5/1-117.1)