FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 21-030-9011
Madden Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation due to a complaint of a potential rights violation in the treatment of a patient at Madden Mental Health Center. The complaint is that a patient's request for discharge was not honored timely and that the patient was not free from abuse.

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. Madden is in Hines, IL and services the greater Chicagoland community as one of two state operated mental health facilities in the Chicago area.

Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 405 ILCS 5/2-112, 405 ILCS 5/2-200, 405 ILCS 5/3-400 and 405 ILCS 5/3-403).

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

COMPLAINANT SUMMARY

It was reported that a voluntary patient was attacked by another patient on the unit. The report indicated that the patient was injured, and the facility did nothing about it. Finally, the report stated that at some point during the hospital stay, the patient requested discharge from the facility and the request was not honored timely.

FINDINGS

"Madden Mental Health Center" Record Review

The facility provided a record that included a master treatment plan, progress notes, reviews of the treatment plan, a request for discharge, a withdrawal of discharge request, an injury report, and a discharge plan. Per the record, the patient was transported to the facility from a neighboring hospital in late October and was discharged in late December. Once at the facility the patient signed a voluntary application and participated in the intake process.

A day after admission the staff attempted to involve the patient in the treatment team meeting. Per the notes the patient was "uncooperative and walked away from the meeting." The master treatment plan reflects that the patient did begin the meeting but did not complete the process. The signature on the master treatment plan is left unsigned by the patient. The master treatment plan also states that the patient "refused" all medication but agreed to participate in some groups.

Two weeks after staff engaged the patient for the master treatment plan, the staff attempted to conduct a treatment plan review. During this review the psychiatrist indicated that the patient was "labile and unpredictable" and the psychiatrist furthered that the patient did not want to discuss her behaviors that "led to current hospitalization." For this review the patient did not add any comments nor did she sign the form indicating she participated in the planning.

The master treatment plan was reviewed for a second time and according to the documentation the patient's disposition had not improved. The patient also did not fully participate in this review as she did not comment or sign the form. However, she was present and encouraged to take medication. The third review happened five days after the second and indicated that the patient was medication compliant and had "slight improvement." The patient also signed this review indicating she fully participated in the meeting.

The next review occurred ten days later and indicated that the patient's disposition had improved. During this review the patient was still medication compliant. The patient signed this review and acknowledged participation. The final review stated that the patient was ready for discharge and encouraged to adhere to medications.

Per the record, the patient did have a physical altercation in November. The notes illustrate that that the patient was attacked by another female patient in the day room. The notes also state that the patient had an injury and a report was filed. The injury report reflects that the patient had a bump on her forehead and no other injuries. The notes indicate that the patient was offered medication and no other medical interventions were offered. Lastly, the notes show no evidence of an investigation into the incident, however they do indicate that the patient was moved from the unit.

The record does contain one request for discharge. The request was received at 2:15 pm on December 9th. The initial request has the patient's printed name, date, and signature on it. The request was received by the social worker, and it is signed and dated by the nurse. There is a

withdrawal of request for discharge in the record that accompanies the initial request for discharge. The withdrawal is dated and signed by the patient and occurs three business days later. The patient was later discharged to the community appropriately.

Site Visit and Interviews

In response to the complaint, the HRA conducted a site visit on September 30, 2021. During the call the HRA asked the staff to explain how a patient obtains a five-day release. The quality control manager responded that all the five-day request for discharge forms are located at the nurses' station on each unit. The social worker furthered that "any patient can ask any staff present for a five-day request for discharge." The medical director and quality control manager concurred with the social worker.

Next, the HRA questioned the staff if they recalled the patient requesting discharge in the treatment plan meeting. The staff informed the HRA that they did not recall the patient making this request. However, the social worker indicated that patients are always engaged in the treatment plan process and discharge planning. The social worker also noted that the patient signed this review of the treatment plan indicating she agreed with the plan.

The HRA asked the staff if an investigation occurred after the altercation that took place between the two patients. The staff responded that the patient was moved to ensure her safety. The staff further indicated that they "require unit staff to write an incident report any time there is an altercation between patients. Administration reviews all incident reports the following morning. We would not conduct an 'investigation' unless there was serious injury or reason to believe that there was abuse or neglect by staff, or if the incident report gave us some reason to believe that staff did not handle the case appropriately."

Policy Review

The HRA reviewed Madden's "Notice of or Request for Discharge (1130)" policy. The policy was reviewed and revised in September of 2020. This policy states that any "voluntary patient may make a written request for discharge at any time from any staff member." The policy continues to state that "the staff must supply the patient with a IL462-2022 form and explain the process and patients' rights." Moreover, the policy details that "once a written request has been received, discharge is not to exceed five (5) days from the date of request, excluding Saturday, Sunday, and Holidays, unless the patient withdraws the request in writing or the facility files a petition and two certificates with the court contesting the patient's request for discharge." Thus, this policy adheres to the requirements of code sections 405 ILCS 5/3-400 and 405 ILCS 5/3-403, as it informs patient of their rights to voluntary admission and the discharge process.

Next, the HRA reviewed Madden's "Admission Screening Requirements (1515)" policy. The policy was last reviewed in February of 2019 and revised in July of 2019. The policy requires that once at the facility the admission coordinator RN must "[p]rovide and review Patient and Family Handbook with patient." The policy also requires the admission coordinator to provide and

review the patients' rights and determine the type of admission that is necessary by completing "appropriate assessments and forms." The policy also indicates that the admission coordinator must review the Patient and Family Handbook with the patient.

Therefore, the HRA reviewed the Patient and Family Handbook. The handbook serves as an overview of the treatment they may receive while at the facility. The handbook notifies patients of their rights as it pertains to treatment, discharge, and admission. The Code requires that at the beginning of services or as soon "as the condition of the recipient permits, every adult recipient … shall be informed orally and in writing of the rights guaranteed by …" the Code. Thus the "Admission Screening Requirements (1515)" policy is in accordance with 405 ILCS 5/2-200, 405 ILCS 5/3-400, and 405 ILCS 5/3-405 as it informs patient of their rights to voluntary admission and the discharge process.

Finally, the HRA reviewed Madden's "Incident Reporting (2735)" policy. This policy was created in November of 1998 and last revised in September of 2020. This policy details that an incident report shall be made to document "any unusual incidents which occur within the Hospital and Region." The policy furthers that incident reports are only filled out by staff and reminds them of Rule 50 reporting obligations. Finally, the policy indicates that all incidents of abuse (physical, mental, emotional and financial) will be referred and investigated by the Illinois Office of Inspector General. Therefore, this policy meets the requirements set by sections 405 ILCS 5/2-112, which stipulate that every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect. Furthermore, the policy tackles the requirements of 405 ILCS 5/3-211 as the facility makes a report and allows an investigation whenever there is suspected recipient to recipient abuse.

CONCLUSION

The patient's five-day request for release was not honored timely.

The record illustrates that the patient filled out a request for discharge on December 9th. There is a subsequent withdrawal of request for discharge in the record that is dated by the patient. The social worker's signature on the withdrawal of request for discharge is dated December 15th, which would be within five business days after receipt of discharge. The record does not have a note that details why the patient withdrew the request for discharge. The notes around the withdrawal of discharge only state that the patient was medication compliant. The record contains a discharge notification and the patient signed off on the discharge. As the patient was voluntary throughout the entire treatment period the discharge was well within Code requirements.

The Code requires that a "voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and

2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court." (405 ILCS 5/3-403) Madden has a withdrawal of request for discharge form; the form has the patient's printed name, time of signature and date. Therefore, based on the information reviewed, a rights violation is unsubstantiated.

The patient was not free from abuse.

The record details that there was a physical altercation between the patient and another recipient. There are two injury reports in the record. However, the HRA did not find any incident reports in the record. Madden's policy indicates that all unusual actions within the facility require an incident report. This action is missing an incident report. Furthermore, there is no real indication in the record as to what happened to resolve the patient's and other recipient's issues. The staff only indicated that the patient was moved. Thus, based on the evidence reviewed, a rights violation is substantiated as Madden violated its own policy and did not meet the entire requirements of 405 ILCS 5/3-211.

RECOMMENDATIONS

1. Retrain nursing staff on incident reporting policies, emphasizing the requirements of 405 ILCS 5/3-211. Provide evidence of the training to the HRA.

SUGGESTIONS

1. Create an altercation checklist for staff to follow ensuring proper documentation is placed in the record.

RESPONSE

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

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

Madden Mental Health Center
1200 South 1st. Avenue • Hines, Illinois 60141

December 23, 2021

Shelia Orr, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
1200 S. First Avenue
Hines, Illinois 60141

RE: **#21-030-9011**

Dear Ms. Orr,

Madden Mental Health Center **received the HRA review** dated 12/6/21 of Case #21-030-9011 **on 12/16/21.** Enclosed, please find our response due 30 days of receipt on 1/15/22.

The facility is not in agreement with and **objects to the substantiated rights violation finding.** Upon review of your report, we have identified some inaccuracies or misunderstandings of our policies and procedures as well as our site interview discussion.

Our enclosed response gives further explanation of our policies and procedures and describes how our actions followed our policies and met the mental health code. Also enclosed is supporting documentation which was available at the time of the review.

We always welcome the opportunity to improve and learn from any complaint or concern our customers may have and from the thorough HRA investigations that ensue. We value your recommendations and are always supportive of retraining staff to ensure they are familiar with and follow policy and statute. In this case, however, since we do not agree that we violated our policy or the mental health code, we do not want to give the impression that we can re-train on something we cannot.

We request that your findings be reconsidered after review of our response. In the event you disagree with our objection and vote to publicly post your report as it stands, then we do request that our objection is included as part of the public record.

If you have any further questions or require any further documentation, please contact me.

Sincerely,

Marquise Byers, Hospital Administrator

Madden Mental Health Center
Facility Response to
Human Rights Authority
Case # 21-030-9011

The facility is not in agreement with the substantiated rights violation finding for case 21-030-9011.

The facility does not agree that we violated our own policy by not placing the incident report in the patient record.

The facility makes the following additional assertions:

1. An appropriate "investigation" was carried out according to policy and the mental health code.
2. The facility responded to the incident appropriately and cared for both patients involved.
3. The facility addressed this incident to resolve the conflict between patients in the most effective way by separating the patients and addressing the individual clinical needs of both patients.

HRA FINDING AND RECOMMENDATION

The record details that there was a physical altercation between the patient and another recipient. There are two injury reports in the record, however, the ***HRA did not find any incident reports in the record.*** *Madden's policy indicates that all unusual actions within the facility require an incident report. This action is missing an incident report. Furthermore, there is* ***no real indication in the record as to what happened to resolve the patient's and other recipient's issues.*** *The staff only indicated that the patient was moved. Thus, based on the evidence reviewed, a rights violation is substantiated as* ***Madden violated its own policy*** *and did not meet the entire requirements of 405 ILCS 5/3-211.*

Section 5/3-211 of the Mental Health Code states the following:
§3-211. ***Resident as perpetrator*** *of abuse. When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that 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.***

FACILITY RESPONSE TO HRA REVIEW

General Policy, Procedure and Definition of terms

OIG "investigations" are conducted only in situations of staff-on-patient abuse or neglect. Incidents of patient-on-patient aggression are not necessarily reported to OIG unless there is credible evidence or concern that the aggression was caused by staff or allowed to occur due to staff negligence. Patient-on-patient aggression is taken very seriously and "investigated" or "evaluated" by hospital staff and administration.

Madden Policy 2735 "Incident reporting" is based on OIG rule 50 and uses OIG definitions of abuse which define various forms of "abuse" as between employee and patient. All forms of suspected **employee** abuse or neglect of recipients are reported to OIG for investigation. Staff are trained on this policy annually.

"Incident reports" are completed for all types of incidents, whether or not they are OIG reportable. This includes patient-on-patient aggression. They are **never placed in a patient record.** They include

identifying information for all parties involved and therefore, cannot be placed in any one individual's chart. They are kept in a separate file with the Safety Officer.

In addition to incident reports, **injury reports** are completed any time an incident occurs in which there is even a potential for injury – including patient-on-patient aggression. Injury reports document medical examinations by both the Nurse and the Physician.

Injury reports are placed in the individual record – even when no injury is sustained - and copies of injury reports are also attached to the incident reports for administration to review alongside of the incident report.

Incident reports and any accompanying documents are reviewed by administration the following morning Monday through Friday. Administration can direct any further follow up or in depth "investigation" or "evaluation" as needed.

Finally, an "incident" is also documented in the **progress notes** of any individual involved.

During and after an incident in which two patients have an altercation, actions are taken by unit staff to first calm and contain the immediate situation and then assess what needs to occur to maintain safety. Staff talk with patients if possible and emergency medication may be administered to help patients calm down. The administrator on duty is notified and a decision is made as to whether the individuals can remain on the unit together, or if patient movement is necessary for safety – both physical and psychological safety. In most cases the victim is asked if they feel safe to remain on the unit or if they would like to be moved to another unit, but decisions are made case by case.

Facility Response to this Incident

In this case, two incident reports were, in fact, completed per protocol for two altercations between this patient and one other patient, which occurred within 30 minutes of each other. Both incident reports indicate that this patient was the original physical aggressor though both engaged in the altercation.

Both incident reports were and are on file with the safety officer and per policy would never be filed in the patient record.

As stated **in HRA's review, there was documentation of the "incidents" in the patient record** though not on an "incident report." Documentation of the incidents are found on injury reports, progress notes, and emergency medication orders.

There were two "injury reports" completed per protocol. These reports document some aspects of the incident, the "evaluations" that both an RN and MD conducted and the "treatment" that was provided in response. As the HRA review noted, the **injury reports** indicated that this patient sustained "a bump on her forehead" in the first altercation but no additional injury after the second altercation. In addition to what the HRA reported, the first injury report also indicates that the patient was given an ice pack and 650mg of Tylenol. No additional medication was given after the second altercation because no additional injury was noted.

Madden Mental Health Center
Facility Response to
Human Rights Authority
Case # 21-030-9011

The incident was also documented in the progress notes per protocol. The progress notes identify this patient as the aggressor and describe the "evaluation" and "therapy" that was given as required by the mental health code. She was placed on special observation every 15 minutes for safety and changes in behavior. She was encouraged to verbalize her feelings and concerns to the staff. There is also documentation in the chart that this patient received emergency medication to assist in calming down with fair effect.

The HRA review, indicated that this patient was moved to a different unit, however, that was a misunderstanding. This patient remained on the same unit and the other patient was moved. The fact that there was patient movement at all, **indicates that an "investigation" by the administrator duty was completed** at the time of the event because patient moves cannot be done without administrative involvement and approval. In addition, since this patient remained on the original unit, and the other patient was moved, that further indicates that this patient was identified as the primary perpetrator of the events. Documentation of the patient movement would have been in the other patient's chart, not this patient's chart.

Finally, the fact that one individual was moved to another unit, thereby separating the individuals, demonstrates that the **conflict was addressed and resolved.** Any further treatment issues the individual had were addressed in the treatment plan. The patient's progress and eventual discharge was clearly documented in the HRA review.

For the reasons delineated above, Madden Mental Health Center does not agree with the finding that we violated patient rights by not following our policy. We further assert that we did meet the entire requirements of 405 ILCS 5/3-211.

We request that this finding be reconsidered.