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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 22-030-9005 & 22-030-9006
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 two previous patients at Madden Mental Health Center. The complaints are as follows:

22-030-9005
A patient was improperly admitted, not explained their rights and not allowed to participate in the formulation of their treatment plan.

22-030-9006
A patient was given forced medications without cause.

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 5/2-107, 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 care provided to each patient. Relevant policies were reviewed as was the patient's record with proper authorization.

COMPLAINANT SUMMARY

22-030-9005

It was reported that a patient was admitted into the facility from a neighboring hospital improperly. The report indicated that the patient did not sign in voluntarily but was kept in the facility for weeks. The report furthered that the patient was not explained their rights and did not participate in the creation of the treatment plan.

22-030-9006

It was reported that a voluntary patient was attacked and sexually assaulted by another patient on the unit. The HRA forwarded the sexual assault complaint to a more appropriate agency. The report indicated that the patient informed the staff but was restrained and given forced medications.

FINDINGS

"Madden Mental Health Center" 21-9005 Record Review

The facility provided a record that included a voluntary application, a master treatment plan, progress notes, reviews of the treatment plan, consent for treatment, designation of emergency treatment preference, acknowledgement of patients' rights, and a discharge plan. Per the record, the patient was transported to the facility from a neighboring hospital in late January with a petition for involuntary admission. The record also details that the patient was discharged in early March of 2016.

Once at the facility the patient signed a voluntary application and participated in the intake process. During the intake process the patient signed a consent for services and the acknowledgement of patients' rights. Both forms are dated as the admission date. The patient also selected her emergency treatment preference as forced medications. The patient then declined to select any advance directives. The progress notes also state, "pt explained intake rules and procedures. Offered snacks and encouraged verbalization of feelings and concerns."

Per the record, the patient participated in the formulation of the master treatment plan two days after admission. The treatment plan is signed by the patient and dated. The master treatment plan indicates that the patient will become compliant with medication and participate in several groups. The plan estimates that the length of stay will be seven to ten days. Outside of the initial treatment plan review the record illustrates that the patient participated in and signed all other treatment plan reviews.

Finally, the record is absent any complaints or grievances filed by the patient. The record is also absent any five-day requests for discharge or any notes detailing that the patient did not want to be in the facility. The included discharge plan illustrates that the patient was in compliance with the plan. The patient was discharged to family with medication and follow up instructions for outpatient psychiatry.

"Madden Mental Health Center" 21-9006 Record Review

The facility provided a record that included two applications for voluntary admission, a master treatment plan, progress notes, a consent for treatment, a request for discharge, restriction of rights forms, an acknowledgement of patients' rights, and a discharge plan. The record details that the patient initially came to the facility in late April of 2007 with a petition for involuntary admission. The petition was accompanied by two certificates from medical personnel at another hospital.

The patient was discharged from the facility in early May of 2007 after submitting a five-day request for discharge. Per the record, the discharge request was processed timely as the patient left the facility within Code requirements. However, the patient was readmitted to Madden at the end of May in 2007.

For the first hospitalization at Madden, the patient signed a voluntary application and completed the intake process. The patient signed the acknowledgement of rights form and consented to taking medications. The patient did not select any advance directive and wrote on the form "I do not want to die!" The patient participated in the intake social assessment, master treatment plan and comprehensive psychiatric evaluation.

The first hospitalization record is the only record that contains any instance of forced medication. The record conveys that the patient's rights were restricted on May 1st, 2007. Per the form, the patient was given Haloperidol 5 mg intravenous and placed in seclusion. The seclusion order accompanies the notice in the record and was ordered by the physician for one hour. The reason for the medication on the form is that the "patient ran into the nurses' station from exam room [and] refused to leave from door, demanded to leave." It then states that "[patient] pulled fire alarm, screaming [and] fighting staff [and] security."

The notice of restricted rights form does not designate if the patient received a copy of the form and the progress notes do not stipulate if the patient received a copy of the notice. However, the progress notes do provide a detailed account of what occurred before the restriction took place. The notes state, "[patient] is in seclusion due to repeated calling 911 and pulling fire alarm. [patient] reported that she was scared because she witnessed her roommate having sex with a fellow patient. [patient] however did not report this to the staff this A.M. even after asking her several times and spending time with her."

To conclude, there are no other restriction of rights in either hospitalization. For both hospitalizations the patient was discharged to family according to Code requirements. For the initial hospitalization there is no evidence of any formal complaints filed from the patient. The record also does not contain any reference to an investigation into the patient's claims.

Site Visit and Interviews

In response to the complaint, the HRA conducted a site visit via WebEx on March 10, 2022. The HRA opened the visit asking the staff about policy changes over the years. The quality coordinator responded that policy and procedures have roughly been the same over the years. The HRA then asked the staff to explain what steps the facility takes to respond to reports of abuse. The staff responded that the first step it to notify leadership that an incident occurred, and a report is created. The next step in the incident reporting process is that administration will review the incident report the next morning after receipt of the report. From there a plan of action is created and a response is given to the applicable parties.

The HRA then asked the staff what the incident reporting process is when sexual abuse is alleged. The staff reported that the clinical care of the patient is always primary. Therefore, if there is a report of this nature the patient is assessed at the time of the report for any emotional, psychological, or physical stress or injury. The staff indicated that if the abuse is staff-to-patient then OIG is called per rule-50. Next, the administrator on duty is notified as well as security. From there a determination of whether police action is necessary occurs, then an incident report is completed. The staff report that the same process is followed for patient-to-patient sexual abuse, except that OIG will not be notified.

Next, the HRA asked the staff if each patient is given a copy of the notice regarding restriction of rights. The quality coordinator reported that each patient is required by the Code to receive a copy of the notice. She furthered that the restriction of rights form even directs staff to provide the patient with a copy of the notice on the form. Lastly, she specified that it is a routine practice that the facility upholds. The HRA then notified the coordinator that for case 22-9006 the box on the restriction of rights notice is unchecked. The HRA also indicated that the record is missing a note detailing if the patient was ever given a notice. The coordinator reported that would be an error on the facility.

The HRA pivoted asking the staff about the treatment planning process. The staff reported that patients are often engaged in the treatment planning process within 72-hours of admission. The staff furthered that patients could speak into their treatment and invite members of their choosing. The physician also reported that patients can make input into the medications they receive. The administrator added that if a patient requests a medication that the facility does not have access to the patient would be offered an alternative medication.

Finally, the HRA asked the staff what happens when a patient refuses to participate in the treatment plan. The staff reported that "if a patient refuses then the expectation is for staff to continue to engage the patient." The staff furthered that sometimes even when a patient refuses, they may engage in one-on-one settings with staff. The staff then ended informing the HRA that patients are always encouraged to participate.

Policy Review

The HRA reviewed Madden's "Refusal of Services/Psychotropic Medication (230)" policy. This policy was implemented in November of 1998 and last revised in March of 2019. The policy

details that a refusal of medication occurs when "verbal and/or non-verbal communication of the patient[s]" indicates an unwillingness to receive medication. The policy further states that when this occurs a "physician must determine if that patient meets the criteria for emergency medication and/or court enforced involuntary medication … [.]"

The policy also has a section entitled "Emergency Psychotropic Medication Administration," that specifies how and when emergency medication should be utilized. The section opens indicating that emergency medication is only administered "to prevent the patient from causing serious and imminent physical harm to self and/or others, and there is insufficient time to give the patient, or his guardian of person, if any, the opportunity to discuss the advantages of receiving psychotropic medication …[.]" This section continues to illustrate that after administration of emergency medication the staff are required to give the patient a Notice of Restricted Rights of Individuals form and document this in the medical record meeting the requirements of the Code (405 ILCS 5/2-201).

Additionally, this policy adheres to the requirements of the Code (405 ILCS 5/2-107) which states that a "recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available."

Then, the HRA reviewed Madden's "Admission Screening Requirements (1515)" policy. The policy was last revised in July of 2019. The policy requires that once a patient enters the facility the admission coordinator RN is responsible for providing and reviewing the "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."

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 the Code's Sections 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.

Lastly, 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 opens defining all the types of abuse. The policy then 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 requirements. 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 section 405 ILCS 5/2-112, which stipulates 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 was admitted improperly, not explained their rights and not allowed to participate in the formulation of their treatment plan.

The record illustrates that the patient entered the facility voluntarily and participated in the intake process. During the intake process the patient signed a consent for services and the acknowledgement of patients' rights. There are notes corroborating that the patient was explained her rights and acknowledged receipt of her rights. Furthermore, the record illustrates that the patient participated in the formulation of the treatment plan. Finally, the patient signed and participated in all treatment plan reviews. Therefore, based on the information reviewed, a rights violation is unsubstantiated.

A patient was given forced medications without cause.

The record details that there the patient was subject to one instance of forced medication. Per the notes the emergency medication was given as the patient pulled a fire alarm and could not be redirected. After the medication the patient was also placed in seclusion with an order in accordance with the Code. However, the record is absent any notation that the patient was given a copy of the restriction of rights form. Furthermore, the restriction of rights form is absent the notation that the patient received a copy. Thus, based on the evidence reviewed, a rights violation is substantiated. Madden violated its own policy and did not meet the entire requirements of the Code (405 ILCS 5/2-201) but the facility acknowledged the error and corrections are already in place.

COMMENT

The HRA would like to recognize that for both complaints the patients were discharged roughly five (5) years prior to complaint. As such the HRA would like to thank the facility for their willingness and readiness to address the issues presented in the two cases.