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Egyptian Regional Human Rights Authority
Report of Findings
08-110-9029
Chester Mental Health Center
July 15, 2008

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 300 male residents. The specific allegation is as follows:

> A recipient at Chester Mental Health Center has not been provided adequate care for a medical condition.

Statutes

If substantiated, the allegation would be a violation of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-102 and 405 ILCS 5/2-112). Sections 5/1-101.1, 5/1-101.2, and 5/1.117.1 of the Code are pertinent to the allegation.

Section 5/2-102 states, "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan."

Section 5/2-112 states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

Section 5/1-101.1 states, "'Abuse' means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means."

Section 5/1-101.2 states, "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

Section 5/1-117.1 states, "'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."

Complaint Information

According to the complaint, a recipient at the facility was not provided with adequate medical care during a medical procedure.

Investigation Information

To investigate the complaint, the HRA Investigation Team (Team), consisting of three members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical chart with his written authorization. The Team also spoke with the Chairman of the facility's Human Rights Committee (Chairman) about the issue. The facility's Policy pertinent to the complaint, as well as information from the Mayo Clinic website were reviewed by the Authority.

Interviews:

Recipient:

The Team spoke with the recipient whose rights were alleged to have been violated when a site visit was conducted. The recipient stated that his bladder was punctured during a medical procedure at the facility, and he has experienced problems with urination since the injury. He stated, "A nurse placed a driver into my penis and semen was extracted in a rough and malicious way. The semen was collected to distribute to others." He informed the Team that the injury occurred in 2007.

Chairman:

When the Team spoke with the Chairman regarding the allegation, he stated that the issue had not been brought to his attention or reviewed by the facility's Human Rights Committee. He stated that he was not aware of any recipient obtaining an injury to the bladder during a medical procedure.

Record Review

Treatment Plan Reviews (TPR):

According to a 01/31/08 TPR, the 75-year-old recipient was originally transferred to the facility on 08/09/96. He was found Unfit to Stand Trial (UST) and transferred to Chester Mental Health Center for his first psychiatric admission. He returned to the county court for an additional hearing in November 1996 where he was placed in a medical unit until May 1997. He returned to Chester Mental Health Center in June 1997 per the county court decision. When the recipient returned to the county court in April 2003, his status was changed from UST to

Involuntary Criminal. His original theim date (anticipated date of release) was listed as 06/12/2097. However, in August 2005 the theim date was changed to 07/17/2036.

The recipient's diagnoses were listed as follows: AXIS I: Bipolar Disorder, most recent episode manic, with psychotic features and Polysubstance Dependence; AXIS II: Antisocial Personality Disorder; AXIS III; History of head injury, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, Hypercholesterolemia, Benign Prostatic Hypertrophy, Bilateral hearing deficit, Left Cataract with Myopia, Positive Purified Protein Derivative (PPD) (TB Skin Test), and Parkinson's Disease; AXIS IV: Psycho Social Problems.

According to the 01/03/08 TPR, the recipient has a goal to reduce psychotic symptoms, which consist of grandiose delusions. Documentation indicated that the recipient was receiving court-ordered medications, which include Quetiapine 50 mg per day for psychosis and mood stabilization and Olanzapine 5 mg if he refuses the Quetiapine. The recipient's Therapist recording pertinent to the goal indicated that the recipient "continues to be delusional and paranoid over past month. He continues to believe he is a doctor and attorney and does not need medication. If he were not on court enforced, he would not take them."

A urological disorder, Benign Prostatic Hypertrophy (enlarged Prostate), was listed as one of the recipient's problems. A goal for the recipient to have no instances of difficulty in voiding was incorporated in the TPR. Objectives listed to achieve the goals included the recipient being compliant with taking prescribed medication, diagnostic and laboratory (labs) testing. Documentation indicated that the Nurse would monitor all of the recipient's labs results and inform the Medical Doctor of any abnormalities. The BMP (Basic Metabolic Panel) indicated that the recipient's calcium level was low. However all other results were within normal limits.

The recipient's TPR also contained goals to address the recipient's problems with bowel elimination, respiratory distress, hyperlipidemia, and his unsteady gait.

A goal for the recipient to have no instance of difficulty in voiding was continued in the recipient's 03/26/08 TPR. No problems in the area were recorded in the progress section pertinent to the goal. Documentation indicated that the recipient was medication compliant, and labs were within normal limits.

In the Extent To Which Benefiting From Treatment Section of the TPR, documentation indicated that the recipient's clinical condition had not changed. His thought processes remained delusional.

Documentation in the recipient's 04/24/08 TPR indicated that the recipient had refused all lab work during the reporting period. The record indicated that he had refused blood draws on 03/17/08, 03/26/08, and 03/28/08. No incidents of difficulty with voiding were recorded.

<u>Monthly Nursing Re-assessment Summaries (Summaries)</u>

The HRA reviewed the Summaries from 03/01/07 through 04/24/08. The monthly summaries document information about a recipient's medical and psychiatric conditions. The following medical information is recorded: vital signs, present weight, ideal body weight range, weight change since last reporting period, type of diet, an overview of medical condition(s) including physical complaints and/or injuries, abnormal lab findings, PRN medication usage, appetite, sleep pattern and hygiene/appearance. The psychiatric assessment records a recipient's medication(s), medication change(s), medication compliance, medication protocol, psychotropic medication consent expiration date, evaluation/side medication effects noted, PRN medication usage, seclusion/restraint usage, any special observation(s), overall behaviors and responses to treatment regimen, any patient education/educational classes and the patient's progress.

Documentation in each monthly assessment indicated that the recipient had not expressed any difficulty with urination. The record indicated that labs were normal for the following periods: 05/14/07 to 06/11/07, 06/11/07 to 07/05/07, 07/07-08/13/07, 08/13/07 to 10/10/07 and 01/30/08 to 03/28/08. Some abnormal labs were noted for the following periods: 03/01/07 to 04/01/07 (Calcium was 8.5 with the normal range listed as 8.6 to 10.6); 04/01/07 to 05/14/07 (blood urea nitrogen (BUN)/Creatinine ratio was 11.1 with normal range listed as 12-20); 12/06/07 to 01/03/08 (BUN/Creatinine ratio was 21 with the normal range listed as 12-20 and the calcium level was 8.5 with normal range listed as 8.6 to 10.6). The record indicated that the recipient did not have any new labs for the assessment period of 10/10/07 to 11/18/07, and he refused to have blood drawn during the 03/28/08 to 04/24/08 reporting period.

Radiology Reports

Documentation indicated that the recipient had two chest x-rays at the facility on 01/25/06 because he had been experienced shortness of breath and had a history of smoking. The Radiology Report indicated that the recipient had (COPD), and an atherosclerotic change in the thoracic aorta.

On 08/28/06 an x-ray of the abdomen indicated that the recipient was constipated. However, there was no indication of a bowel obstruction. Two calculi (kidney stones) were also noted over the left kidney.

Three x-rays of the right hand were taken due to the recipient having pain and bruising in the hand. Findings indicated that the alignment was normal; however, there was indication of arthrosis (degeneration) of the interphalangeal joints (finger bones) and carpus (wrist).

According to the record, the recipient had two chest x-rays on 10/09/07 because he had been experiencing some shortness of breath. Radiology findings indicated that the recipient had COPD with stable chronic changes; however, he had no active lung disease.

The recipient received a Computed Tomography (CT) scan of the head, CT scan of the Maxillofacial bone and a CT of the cervical spine on 02/08/07 after he experienced a fall. Findings indicated that the recipient had a fracture in the nasal and cheekbone area and moderately severe degenerative disc disease of the spine with no acute fractures. Per the CT scan

of the head, there was no indication that the recipient had experienced an infarct (stroke) or hemorrhage of the brain to cause the fall.

Electrocardiograms completed on 02/23/07 and 10/09/07 indicated normal findings for electrical activity in the recipient's heart.

Additional Chart Review

The HRA did not observe any documentation in progress notes, medical notes, etc. that indicated that the recipient had any medical treatments or diagnostic procedure of the urinary tract or the genitals that could have possibly caused the injury described in the complaint.

Conducting Initial and Annual Physical Examination and Medication Histories Policy (Policy).

According to the Policy, each recipient is examined by a qualified physician within twenty-four hours of admission and annually thereafter. The physical examination is a part of a physical health assessment that includes medical history, functional assessment screening, bowel elimination assessment and appropriate laboratory work-up.

The medical history includes the following information: the recipient's main complaint; details of present illness; when appropriate, assessment of a patient's emotional, behavioral and social status; relevant past and family histories; an inventory of body system and alcohol and drug history.

The Policy states that the physician will also complete nutritional, occupational therapy, physical therapy, speech therapy and audiological assessments. Any significant finding will result in a physician's order for a referral for appropriate follow-up services.

The physician, in conjunction with the admitting nurse, will complete an Initial Bowel Elimination Assessment on all new admissions, and significant findings will be documented in order for interventions to be initiated.

According to the Policy, the physician should also indicate whether there are any pre-existing medical conditions or physical disabilities/limitations that would place the recipient at greater risk during restraint and seclusion.

Any special problems, precautions, or considerations, including significant physical disorders or conditions for inclusion on Axis II, should be documented and presented at the 3-day Treatment Plan meeting.

The Policy mandates that a summary of the findings obtained during the recipient's physical examination and medical history be conveyed to the recipient, or if under guardianship, his guardian.

Additional physical exams, laboratory testing, and diagnostic procedures are to be conducted as needed during the recipient's hospitalization at the facility.

Information from Mayo Clinic Website

According to the MayoClinic.com website, Benign Prostatic Hypertrophy is an enlargement of the prostate. Documentation indicated that most men eventually develop some prostate enlargement as they age, and about half of these men develop lower urinary tract symptoms that are so bothersome that they seek medical treatment. Symptoms such as a weak urine stream, difficulty starting urination, stopping and starting again while urinating, the frequent need to urinate, increased frequency or urination at night, the urgent need to urinate, an inability to empty the bladder, blood in the urine and an urinary tract infection may be caused by the obstructed urine flow due to the enlargement of the prostate. The symptoms may also be caused by an irritation in the bladder or urethra, or may be a combination of both.

Summary

According to the complaint, the facility did not provide adequate care for a recipient's medical condition. When the Team spoke with the recipient whose rights were alleged to have been violated, he stated that an RN at the facility punctured his bladder during a procedure to extract semen. According to documentation in the recipient's clinical chart, the recipient had a diagnosis of Benign Prostatic Hypertrophy, an enlargement of the prostate. Whenever the HRA reviewed Monthly Nursing Assessments from March 2007 through April 2008, documentation indicated that the recipient had not complained of any problems with urination, a symptom associated with the diagnosis. The HRA did not observe any information in the recipient's chart that indicated that catherization was necessary due to the recipient's inability to urinate. Nor was any documentation observed regarding medical treatment(s) or diagnostic procedure(s) of the urinary tract or genital area, which resulted in any type of injury. When the Authority reviewed information throughout the recipient's clinical chart, it was determined that the facility had followed it's own policy pertinent to medical assessment and care.

Conclusion

Based on the information that was obtained during the investigation, the HRA does not substantiate that the recipient did not receive adequate care for a medical condition. No recommendation(s) are issued.