FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
TINLEY PARK MENTAL HEALTH CENTER— 09-040-9010
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made four corrective recommendations regarding two of the allegations, and the service provider accepted all of them. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations concerning Tinley Park Mental Health Center, a state-operated facility. The complaint alleged the following: 1) a recipient was not provided with adequate medical care, 2) the recipient was not allowed to review his record upon request, and, 3) the facility did not return the recipient's property at discharge. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4).

METHODOLOGY

To pursue the investigation, the facility's Attending Psychiatrist, the Business Administrator and a social worker were interviewed. The recipient's record was reviewed with his written consent. Relevant facility policies including the Department's personal health information policy were also reviewed.

COMPLAINT STATEMENT

The complaint specifically stated that the recipient had problems with sleeping, but medication was denied. He requested to inspect his medical record, but a staff person told him that the physician's approval was needed. He was reportedly allowed access to his record after he called an advocacy group. Additionally, the complaint alleged that the recipient's property was not returned at discharge because the facility's trust fund is closed on Saturday. His belongings were mailed to his mother about a week later.

FINDINGS

After reviewing the record, the HRA determined that the recipient was transferred to Tinley from a community hospital on December 11th, 2008 after he had allegedly swallowed

about 30 pills. The Comprehensive Psychiatric Evaluation including the Physical Examination Report, completed by the intake physician, documented feelings of depression and auditory hallucinations. The recipient had been using cocaine for about 20 years and said that he had ingested cocaine the day before his suicide attempt. He was on "police hold" for retail theft, he was homeless, and he had been discharged from the facility in October 2008. The recipient reported having problems with sleeping and Gastroesophageal Reflux Disease (GERD). The physical examination did not reflect that the recipient had serious medical problems or pain.

The recipient was diagnosed with a Mood Disorder, Psychosis and Cocaine Dependence upon his admission to the facility. The Admitting Physician also wrote that Substance Induced Mood Disorder needed to be ruled out. Seroquel 600 mg for psychosis, Cymbalta 60 mg for mood disorder and depression, Thiamine 100 mg for substance abuse, Trazodone 100 mg for insomnia and Omeprazole 20 mg for GERD were ordered. These medications reportedly had been prescribed prior to the recipient's intake with the exception of Thiamine. He signed a consent form for the medications and a Voluntary Application during the admission process.

A history and physical assessment written on December 12th stated that the recipient did not have problems with falling asleep, but he was constantly waking up. He reported sleeping about five hours daily for the past two weeks and that "demons" were talking to him. His primary diagnoses were recorded as Cocaine Dependence, Malingering and Substance Induced Mood Disorder. (The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition defines Malingering as intentionally exaggerating symptoms of a mental or physical disorder for external incentives). The Inpatient Comprehensive Psychiatric Evaluation, the Master Treatment Plan and a social assessment were completed on that same day. The Attending Psychiatrist wrote that the recipient has been hospitalized more than thirty times because of cocaine use. He claimed that voices were telling him to harm self. The psychiatrist made changes to the recipient's treatment plan. Trazodone was discontinued on that same day and Cymbalta was decreased to 30 mg and discontinued three days later. Seroquel was reduced to 500 mg and decreased by 100 mg over four days and discontinued. Although the resident signed the plan, there was no indication that he was offered a copy of the document.

The "Daily Patient Care Assessment Flow Sheets" indicated that the recipient slept five to seven hours each night during his stay. There was no documentation that he had problems falling or staying asleep at night. On December 17th, a physician's entry stated that the recipient objected to being discharged on the 18th because he wanted more medication. The recipient stated, "I feel crazy" [and that] "my nerve-endings are jumping" on that next day. He reported having taken Trazodone for sleeping purposes about 10 years, and that he did not want to go to jail without medication. The Attending Psychiatrist wrote that there was no evidence of a mood or psychiatric disorder or need for psychotropic medications. However, an order written on December 20th indicated that Trazodone 50 mg for sleep was restarted by the Admitting Physician. According to medication records, Trazodone was administered for three days and discontinued.

There was no documentation that the recipient requested to review his record, but progress notes and reports indicated that he disagreed with his diagnoses. According to a Utilization Review Panel Report dated December 26th, the recipient was "tenacious in his

assertions of mental illness [versus] cocaine addiction" during his hospital visit. He objected when medications were discontinued, and he did not participate in other modes of therapy. The review panel upheld the clinical team's decision that the recipient no longer required inpatient care. A social worker made arrangements with the police regarding his scheduled discharge for December 27th. On the discharge day, the recipient was given a two week supply of Omeprazole 20 mg and all of his belongings on the unit. The recipient refused to sign the Discharge Summary. He told the staff person that he did not get his property from the facility's trust fund before he was escorted off the unit by Tinley's security staff. A "Personal Property Receipt" indicated that the following items were placed in the facility's trust fund at intake: 1) four identification cards, 2) a bus pass, 3) three razors, 4) one belt, 5) one aerosol spray can, and, 6) one pair of sunglass. The form documented that the above items were mailed to the recipient's parents on January 6th, 2009 after several attempts were made to locate him. Another property sheet recorded the following items: 1) one pair of boots, 2) one pair of pants, 3) two jackets, and, 4) three tee shirts. The form requires documentation regarding whether the recipient's property was stored on the unit or the individual kept them in his possession or they were sent home. This was not recorded on the form.

At the site visit, the Attending Psychiatrist explained that the recipient's primary problems were Substance Abuse and Personality Disorder. His symptoms of depression, overdosing on medications and insomnia were exaggerated. His motivating factors were possibly shelter, avoiding going to jail or getting disability benefits from the Social Security Administration. He said that sometimes recipients verbalize feelings of depression, but they are later observed laughing or playing cards with peers. The psychiatrist reportedly changed the recipient's initial psychotropic medication regimen that included Seroquel, Trazodone, and Cymbalta. The HRA was informed that Seroquel (street name is "Suzy Q") has a sedative effect and that recipients sometimes demand the medication. He disagreed with the covering physician who restarted Trazodone on December 20th. The psychiatrist said that medication used for sleeping purposes make the problem worse when a person abuses drugs. A person's sleep habits usually become normal after several months of sobriety.

Although there was no documentation that the recipient requested to review his record, a request was confirmed by the social worker. He explained that the record request was discussed with the Attending Psychiatrist because they are a team. The record review reportedly took place in the social worker's office, but he could not remember the date. It was reported that the recipient was concerned about the word "malingering" in his chart. The psychiatrist said that sometimes staff is needed to explain certain word to recipients during the review. According to the social worker, the facility's policy does not require a written request for recipients to review their records. The recipient involved in the complaint is reportedly the only consumer who has made such a request within the last three years.

When the recipient's property was discussed with the staff, the HRA was informed that Tinley's trust fund is opened Monday through Friday from 8:00 a.m. to 4:00 p.m. The facility's Business Administrator asserted that maybe the recipient's items were not picked up from the trust fund on the discharge day because the police did not want to get them. The business office mailed his belongings on January 6th to an address found in the record. On questioning, the social worker agreed with the HRA that arrangements should have been made for the recipient's

property to be released from the trust fund on Friday, December 26th when his discharge was determined.

According to Tinley's "Assessment of Patient Needs" policy, each patient presenting to the facility for services shall receive a comprehensive, multi-disciplinary assessment that indentifies their individual needs. The assessment information is integrated into a Master Treatment Plan that addresses the patient's individual needs and goals. The Admitting Psychiatrist is responsible for developing the initial treatment plan. A medical history and physical assessment must be done, which includes a pain screening within 24 hours of admission. A psychiatric evaluation, social investigation and the Master Treatment Plan must be done within 72 hours.

According to the facility's consumer's rights statement #29, consumers have the right to examine their medical records in a reasonable time frame, unless a clinical determination is documented that such access would be seriously detrimental to their health or treatment progress. A request and review of a consumer's chart shall be noted in the chart. If the request is denied, the reason shall also be recorded in the chart. Additionally, the policy states that staff will be present to explain or interpret information in the record.

The Illinois Department of Human Services' "Individual Rights - Inspect and Copy PHI" policy (#01.01.02.110) states that a written request is required to inspect and copy protected health information. The Department shall act on the request for access within 30 days unless more stringent federal or state laws or regulations are applicable. The decision can be appealed if the requestor is denied accessed because of substantial harm to self or others.

According to the facility's policy entitled, "Personal Property and Searches of Recipients," any person presenting for evaluation and possible admission shall be immediately searched for contraband. All items in the recipient's possession shall be carefully inventoried and listed on the Personal Property Receipt form upon admission. Any property taken to the unit by the patient or placed in the facility's trust fund shall be recorded on the form. Valuables (jewelry, currency, credit cards, keys, electronic, etc) should be photographed by the facility's security staff, placed inside a property bag, locked in the presence of staff and patient, and deposited in a locked drop box. All other property shall be placed in a brown bag marked with the patient's name and the assigned unit. The nursing staff shall review all items on the unit property sheet with the patient on the evening prior to discharge. All money and property held by the trust fund will be returned to the recipient after showing the Discharge/Transfer Summary to the clerk.

CONCLUSION

According to the Code, Section 5/2-102 (a) states that a recipient of services shall be provided with adequate and humane care and services, pursuant to an individual services plan.

Section 5/3-205.5 of the Code requires the facility to provide or arrange for a comprehensive physical, psychiatric evaluation and a social investigation within 72 hours of a recipient’s admission, excluding Saturdays, Sundays and holidays.

Section 5/2-104 (c) of the Code states that when a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him.

Pursuant to Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act,

> A recipient shall be entitled upon request, to inspect and copy a recipient's record or any part thereof "if the recipient is 12 years of age or older." Whenever access or modification is requested, the request and any other action taken thereon shall be noted in the recipient's record.

The Authority finds that the recipient was provided with adequate medical care. Supportive documentation indicated that the recipient received all evaluations and assessments as required by policy and within the Mental Health Code's 72 hour time frame. The recipient was provided with services outlined in his treatment plan developed by the clinical team for his individual needs. The Attending Psychiatrist reportedly discontinued Trazodone for sleep because he believed that the recipient was exaggerating his symptoms. No violations of Sections 5/2-102 (a) or 5/3-205.5 were found. The complaint is not substantiated.

There was no documentation in the record that the recipient requested to review his record, but the social worker reported that a record review occurred after the request was discussed with the Attending Psychiatrist. Tinley violates Section 110/4 of the Confidentiality Act and the facility's consumer's rights statement #29 because there was no written documentation of his request in the record. The Department's policy and the facility's rights statement #29 also violate patient's access to records under Section 110/4. There is no provision in the Act that gives the Department or facility the authority to require physician approval and to deny record access or to any part of it. The Act goes on to state that access may not be denied or limited if a recipient 18 years or older refuses assistance in interpreting the record pursuant to Section 110/4 (b). The complaint that the recipient was not allowed to review his record upon request is unsubstantiated.

Additionally, the investigation confirmed that the recipient was discharged on Saturday, December 27th, 2008. A property receipt indicated that the recipient's items placed in the facility's trust fund were mailed to his parents after he was discharged. The HRA understands that the trust fund is closed on the weekend. We appreciate Tinley's efforts to return his belongings to him after discharge, but they should have been prepared on Friday because all lawful property shall be returned at discharge. The complaint that the facility did not return the recipient's property at discharge is substantiated. This violates rights under Section 5/2-104 (c) of the Code and the facility's policy.

RECOMMENDATIONS

1. Follow the Mental Health and Developmental Disabilities Confidentiality Act Section 110/4 and document all requests for access to records in recipients' charts.

2. Revise the facility's consumer's rights statement #29 that address recipients' request to review their records in accordance to Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act.

3. Follow Section 5/2-104 (c) of the Code including Tinley's policy and ensure that all property is returned when recipients are discharged.

4. Record on property forms the disposition of recipients' belongings not placed in the facility's trust fund.