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REPORT OF FINDINGS
TINLEY PARK MENTAL HEALTH CENTER— 09-040-9012
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority's corrective recommendation was accepted by the service provider. 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 an allegation concerning Tinley Park Mental Health Center, a state-operated facility. The complaint alleged that a recipient was not provided with adequate and humane care concerning pain. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]) and the Illinois Administrative Code for state-operated facilities (59 Ill. Admin. Code 112).

METHODOLOGY

To investigation the complaint, the Attending Psychiatrist, the Clinical Nurse Manager, the Recovery Specialist and two Registered Nurses were interviewed. The recipient's record was reviewed with his written consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, on February 25th, 2009, the recipient requested Ibuprofen for his toothache that had been ordered as needed every eight hours. The nurse on the night shift told him that it was too early for the medication. The recipient told the nurse that he had received a pain pill around 5:00 p.m. on the previous day, but she said that the medication had been given around 7:00 p.m. Another nurse told the recipient that they were not going to argue with him and slammed down the phone after talking to the physician at the recipient's request. She then said that he would have to wait until 3:00 a.m. for pain medication, but the medication was given around 2:40 a.m. The recipient asked the nurse who had administered the pain medication on the evening shift about the time discrepancy. The nurse allegedly said that the medication had been given after dinner and that the time had been changed from 17:00 hours (5:00 p.m. regular time) to another time on the medication record. It was reported that the Patient Advocate filed a written grievance with the facility on the recipient's behalf concerning the incident.

FINDINGS

The record indicated that the recipient denied having pain when he was triaged on February 2nd, 2009. According to the Comprehensive Intake Psychiatric Report, the recipient had been transferred to the facility from a local hospital because of a suicide attempt. He acknowledged taking excessive amounts of Cocaine, Skelaxin (a muscle relaxant) and other substances leading up to his hospital visit. He reported having a toothache on and off for two years and that the pain had worsened during the past month. The psychiatrist wrote that Major Depression needed to be ruled out, and the recipient was voluntarily admitted to the facility on that same day. The admitting orders included laboratory work, Zolpidem 10 mg nightly for sleep and Ibuprofen 800 mg as needed every eights hours for pain. A Physical Examination Report including a Medical History Report also referenced that the recipient's primary physical complaint was a toothache. An Electrocardiogram was not required because the test had been completed by the emergency room staff. His initial treatment plan addressed his suicidal ideations.

On February 3rd, the recipient was evaluated by the assigned psychiatrist and a general medical physician. The physician wrote that the recipient had dental caries (decay) at the upper set of molars and that the left and right gums were swollen. He had been previously prescribed medications for his toothache, but he did not have any money to get the prescriptions filled. His toothache was secondary to dental-related infection, and Amoxicillin 500 mg three times daily was ordered. A goal objective stating that the recipient would comply with medications for his dental-related problems was added to his treatment plan. Later that evening, the recipient rated his tooth pain as an "8" on a scale of "10" being the highest number. The nurse also recorded on the pain assessment form that eating and cold liquids aggravated his problem. Ibuprofen and Amoxicillin were administered, and the pain medication was reportedly somewhat effective.

On February 4th, the Comprehensive Inpatient Psychiatric Evaluation and the 72-hour treatment staffing were completed. The recipient was diagnosed with Substance Induced Mood Disorder and Cocaine and Marijuana Abuse. His treatment plan included goal objectives concerning depression, substance abuse and his toothache. The recipient signed the plan that documented his involvement in the treatment planning process, and a copy of the plan was offered. Citalopram 20 mg every morning was subsequently added to the recipient's medication regimen with his written consent. He later reported having pain on both sides of his mouth and that tooth extractions and possibly root canal work had been previously recommended. But he was unable to follow up with the dental recommendations because he lacked medical insurance. According to Medication Administration Records (MARs), Amoxicillin was administered three times, and Ibuprofen was given twice on that same day.

The Social Assessment was completed on February 5th with information obtained from the recipient. Entries indicated that the recipient continued to complain about tooth pain, and medication was offered. According to MARs, Amoxicillin was administered three times on February 5th through the 9th, twice on the 10th, one time on the 11th and the medication was discontinued. By documentation, Amoxicillin was not offered three times as ordered on the 10th. Ibuprofen was accepted two or three times on February 5th through the 10th. The next dose of pain medication was accepted on the 16th. On that same day the psychiatrist wrote that the recipient's mood and sleep pattern had improved. And, he was eating okay, and his pain was

manageable. Ibuprofen was administered on the 17th at 17:00 or 19:00 hours, which translates to 5:00 p.m. and 7:00 p.m. regular time, and on the 18th at 2:45 a.m. Later that day, the recipient told the general medical physician that he was still having toothaches, but the pain had not worsened. The physician also recorded that the recipient was planning on following up with a dentist post-hospital discharge. On that same day a warm pad for the recipient's cheek four times daily for three days was ordered. By documentation, the physician's order was not followed by the nursing staff.

According to the MARs, Ibuprofen was accepted two or three times on February 19th through the 23rd. A psychiatry note repeated that the recipient was improving and that his pain was manageable four days later. The pain medication entries on the 24th and the 25th were closely reviewed because the complaint alleged that medication was accepted at 5:00 p.m. and 2:40 a.m. respectively. The medication records documented that Ibuprofen was given on the 24th at 10:35 a.m. and 21:00 hours (9:00 p.m.) and on the 25th at 8:00 a.m., 5:40 p.m. and 8:15 p.m. There was no clear documentation that pain medication was given at around 2:40 a.m., except on the 18th. A physician's entry written on March16th reflected that the recipient's tooth pain was minimal, and the record showed that he accepted as needed Ibuprofen until discharged on March 23rd, 2009. He was given a two week supply of Citalopram, five dosages of Ibuprofen 800 mg and referrals for his physical and mental health needs.

When the complaint was discussed with the facility's staff, the Attending Psychiatrist said that Ibuprofen was managing the recipient's pain, but he might have wanted a stronger medication. He said that the recipient had been given a prescription for Norco (a stronger pain medication) prior to his hospital visit, but he did not have money to get the prescription filled. The facility reportedly does not have a dentist, but the recipient would have been seen by an oral surgeon if his condition had been chronic. The recipient would have been referred to a nearby state-operated facility that has an extended care program if he had been in Tinley's long-term care program.

A Registered Nurse said that the incident in question occurred on the morning of February 18th instead of the 25th as reported in the complaint. The nurse confirmed that he told the recipient that the pain medication had been given on the previous evening at 5:00 p.m. (17:00 hours). He said that the nurse on the night shift might have misread the time as 1900 hours instead of 17:00 hours on the medication record. The night nurse explained that the recipient requested pain medication for his toothache shortly after her shift had started. She said that he might have asked for the medication around 11:15 p.m., but the medication record showed that the previous dose had been given at 17:00 or 19:00 hours. The recipient was informed that he would have to wait two or three hours for the medication, but he insisted on getting the medication right away. She asked another nurse to review the time on the medication record. She called the physician who said that he would have to wait until the next dose was due. The nurse stated that Ibuprofen 800 mg should not be given in close intervals because the medication is too strong. The recipient reportedly went to bed, he got back up, and the pain medication was given. The nurse did not acknowledge that she slammed down the phone but she said that this would have been directed at the physician, if occurred.

There was no written grievance found in the recipient's record. The facility's Recovery Specialist who serves as the Patient Advocate did not remember talking to the recipient about the incident. She said that a written grievance was not filed with the facility and that she had also checked with the Unit Manager concerning this issue.

According to Tinley's policy entitled "Assessment of Patient Needs," each patient who presents to the facility for services shall receive a comprehensive, multi-disciplinary assessment that indentifies his individual needs. The information gathered in the assessment process is integrated by the treatment team 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. The unit psychiatrist must interview the recipient and complete a psychiatric evaluation within 72 hours. A social investigation and the Master Treatment Plan must also be done within the 72 hour timeframe.

According to the facility's policy entitled "Case Management," the assigned physician is responsible for making diagnoses and implementing a course of treatment. The assigned nurse is responsible for implementing the orders as prescribed by the physician.

Tinley's grievance policy states that a patient, family member or representative may file a grievance without reprisal such as termination of stay. The complaint should be written on the facility's grievance form and submitted to the Clinical Nurse Manger. The policy includes steps for resolution up to the Facility Director or designee. During the grievance process, the patient can choose to submit his/her complaint to an external agency such as the Guardianship & Advocacy Commission, Human Rights Authority at any point. It states that the facility must provide a written response within two to five business days depending on the grievance level. The policy does not include notification concerning what steps were taken to investigate and contact information.

CONCLUSION

The Illinois Administrative Code (59, Section 112.30) requires that,

> Each person admitted to the Department in accordance with the Code [405 ILCS 5] shall have a thorough physical examination on admission.… Persons with mental illness shall be examined within 24 hours in accordance with the Mental Health Standards…. The examination shall include an evaluation of the recipient's condition, including … diagnoses, plan of medical treatment, recommendations for care, including personal care needs, treatment orders … and any other required examinations…. An electrocardiogram (EKG) shall be provided within three days after admission, excluding Saturdays, Sundays, and holidays, for any recipient age 40 or over, except that an admission EKG need not be repeated on readmission if one was provided within the

> previous 12 months during a prior admission, unless otherwise clinically indicated by the examining physician….

Section 5/2-102 (a) of the Mental Health Code guarantees all recipients of services that adequate and humane care and services shall be provided, 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.

According to the record, Ibuprofen as needed every eight hours was ordered at intake on February 2nd, 2009. The facility completed the comprehensive physical examination, psychiatric evaluation within 24 hours in accordance with the Illinois Administrative Code (59, Section 112.30) even though the Code's Section 5/3-205.5 allows 72 hours. A social investigation was completed within 72 hours. Amoxicillin for the recipient's dental infection was ordered on February 3rd. The recipient was seen by the assigned psychiatrist and a general medical physicians many times during his hospital stay. Ibuprofen was frequently administered for the recipient's tooth pain, and physician's entries indicated that the medications for his dental-related infection were helpful.

The Registered Nurse who administered the pain medication on the evening of February 17th did not confirm that he told the recipient that the time had been changed on the medication record. He explained that the nurse on the night shift might have misread the time as 19:00 instead of 17:00 hours. According to the nurse on night shift, the time written on medication record was difficult to read. She reported that the physician said that the recipient would have to wait for the pain medication. Ibuprofen was given on the 18th at 2:40 a.m., according to the record. The investigation did not reveal that a grievance was filed with the facility.

The Authority finds that the recipient was provided with adequate medical evaluations. However, the nursing staff failed to provide adequate care because physicians' orders were not followed. There was no indication that Amoxicillin was offered three times as ordered on February 10th. A warm pad for the recipient's cheek was not offered three times daily for three days as ordered. Ibuprofen was given on February 25th at 5:40 p.m. and 8:15 p.m. but the medication should have been given as needed every eight hours. This violates Section 5/2-102 (a) of the Code and the facility's policy.

RECOMMENDATION

1. Based on a recent investigation (case #09-040-9007), the HRA is aware that Tinley has retrained its nursing staff regarding medication administration. The facility provided documentation that this issue was discussed with the appropriate staff on March 10th, 2010. However, the Authority must again recommend that the nursing staff follow all physicians' orders as written to ensure that recipients are provided with appropriate medical care under Section 5/2-102 (a) and the facility's "Case Management" policy.

COMMENT

The Special Provisions Applying to Psychiatric Hospitals Section of the Medicaid Participation requirements states that the hospital must meet conditions specified in Sections 482.1 through 482.23 (42 C.F.R. 482.60).

Under Section 482.13,

> The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care…. At a minimum:
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> (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.
> (ii) The grievance process must specify time frames for review of the grievance and the provision of a response.
> (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

Because the facility's grievance policy was reviewed in case #09-040-9007 and the current case, we again suggest that the facility should revise its policy to state that written responses must include the steps that were taken to investigate the grievances and contact information as required by the CFR.