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North Suburban Human Rights Authority
Report of Findings
Elgin Mental Health Center
HRA #09-100-9006

Case Summary: the HRA did not substantiate the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elgin Mental Health Center (EMHC), Forensic Treatment Program, Pinel Unit. In August 2008, the HRA notified EMHC of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The following complaints were accepted for investigation: staff members are negatively charting on a consumer when a concern is presented; a consumer received inappropriate medical care subsequent a foot injury; and, staff members determined that the consumer needed an escort to pick up packages at the security office without cause. The rights of consumers receiving services at EMHC are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102).

To pursue this investigation the HRA reviewed, with written authority, a portion of the clinical record (April and May 2008) of the consumer whose rights were alleged to have been violated. An on-site visit was conducted in October 2008, at which time the allegations were discussed with the consumer's Physician, an attending Physician, two Security Therapy Aides (STA), and the consumer's Case Worker. The HRA was unable to interview the Security Officer identified in allegation as he is on extended medical leave. The consumer was also interviewed via telephone and in person.

Background

Consumers receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need. Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 315 beds.

Allegation: staff members are negatively charting on a consumer when a concern is presented

Findings

The consumer whose rights were alleged to have been violated is a 39 year old male who was remanded to DHS in December 2000. He reported to the HRA that the staff documenting in his record reflects undue negativity with regards to various incidents in which he was involved. He claims that small incidents get blown out of proportion by the staff and that little is done to document positive activities in which he is involved. He feels that this is a universal problem affecting all of the consumers and that it is a frequent topic of conversation during their meetings. He voiced that he sees himself as an advocate, not only on his own behalf, but on behalf of all of the consumers in this regard. In his opinion, the other consumers are afraid to aggressively voice their complaints for fear of retribution and that he feels that the current system of documentation in the record needs to be changed. He admits that there is some positive charting, but very little in comparison to the overall negative tone in the chart. He said that while it is possible that different people may have different views of the same incident, the negative charting is out of proportion to what in fact occurred – so much so that it cannot be explained by a simple difference of opinion or personal viewpoint. The consumer pointed out that this negative charting can make its way into the treatment plan, and can ultimately be used in court to the detriment of his position. He also pointed out that the majority of the charting is done by the STAs, who tend only to record negative events in their documentation. He believes that management staff are much more positive in their documentation.

The consumer provided the following examples from his chart: It was documented that the consumer contacted an outside entity and made a medical appointment - the consumer states that he called the medical clinic and the nurse hung-up on him; the nurse then called the unit and made the appointment. Thus, the reporting is false/inaccurate in that he did not actually make the appointment.

The consumer disputes an event that happened while picking up packages; staff documented that the consumer interfered with security and gave security a hard time - the consumer claims that he and security had a civil conversation about the Center's personal property policy. Another disputed event was an entry that indicated that a staff member from another unit called the Pinel unit staff about the consumer's behavior while he was on a grounds pass. The staff member reported that the consumer was talking to consumers over the fence and repeated requests were made for him to move along. The consumer disputes this, saying that no one told him to leave from the fence area, and he only heard about this when he returned to the unit. The HRA interviewed the staff member who made the repeated requests. She stated that consumers on a grounds pass are not to interact with the consumers in a secured courtyard for safety reasons. She recalled that she and a Lead STA asked the consumer several times to not interact with a couple of the female consumers contained in the courtyard. When the requests were ignored, the Lead STA instructed the other STA to contact this unit and report the refusals. The HRA then spoke to one of the female consumers; she also stated that she remembered staff members telling this consumer numerous times to leave the fence area. She readily recalled this event because she stated that the consumer had subsequently accused her of disclosing the matter to her unit staff who then contacted his unit staff.

The consumer wrote this same concern to the Acting Forensic Program Director, and a copy of the Director's response (3/2008) was given to the HRA. The Director wrote that when the consumer reports legitimate concerns to staff that those concerns should not be held against the consumer nor should the staff negatively chart on reporting concerns. The letter further stated that all notes in the chart should be objective and factual. The Program Director wrote that he discussed these concerns with the Unit Manager who stated he would follow-up with staff and review the chart for any inappropriate documentation.

In discussing this matter with the consumer's Caseworker, she offered that she is very familiar with this complaint. She said that initially the consumer would review his record with her on a weekly basis and he would frequently request that he be allowed to add his own addendum to the record – which he was allowed to do. She said that recently he has been reviewing the record less frequently and has been adding fewer addendums.

The Caseworker stated that the consumer is doing very well overall and that there is some anticipation of a discharge. She stated that the staff on the unit are supportive of his improvement and ultimate discharge and that undue or unnecessary negative charting would not be helpful in achieving these goals. She felt that the charting is factual in nature with many direct quotes and that only major significant issues would warrant documentation, and generally have supporting witness confirmation. She did agree that the charting tends to be of an "Incident Reporting" nature, in so far that it is unusual incidents which tend to be reported, and that such incidents in a general sense tend to be negative in nature.

A review of the record showed that during the two month period, the STAs had about eight entries documented in the chart. The Center's four page Progress Note Documentation policy states (in part) that progress note documentation shall be used to provide a chronological, continuous, and integrated account of the recipient's progress.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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."

The HRA cannot discount the consumer's claim that staff members are negatively charting on a consumer when a concern is presented. Although there is nothing to substantiate the allegation that the negative charting is unwarranted or fraudulent, it does seem that the rational for the STA documentation is that of "incident reporting" and that by definition tends to be negative.

The HRA suggests that positive progress note documentation be encouraged.

Allegation: a consumer received inappropriate medical care subsequent a foot injury

Findings

In early April 2008, the consumer underwent an excision of a neuroma from the bottom of his right foot at the University of Illinois at Chicago Hospital and Health Systems (UIC). The consumer reported to the HRA that in late April his foot began to hurt– perhaps because he stubbed or twisted it – and he complained to the Center physician. He stated that he received only a cursory examination (May 2) and due to his concern, he contacted the UIC Podiatry Clinic and had his follow-up appointment advanced. The consumer strongly asserts that there must have been something wrong with the wound on May 2nd, and that had he not made the call to the UIC, the injury could have progressed into something much worst.

According to the clinical record, as stated above, in early April the consumer underwent an excision of a neuroma. There was no clinical evidence of any overt infective process, per the medical documentation, at that time. An examination on April 29th noted that the wound was "swollen"; there was no noted evidence of an infection (no drainage or discharge). On May 2nd, the foot was described as "swollen and purple" and the consumer reported that he felt that it was "infected". On May 3rd an abscess and substantial infection process was documented. An incision and drainage of the abscess was performed at the UIC clinic on May 5th. Documentation indicated that the site healed well and by May 24, the consumer had resumed activities as tolerated.

The Center Physicians explained that they provide follow-up care. There are three full time (8AM-4PM) Physicians responsible for the medical care of the approximate 300 consumers. Additional Physicians provide in-house night and weekend coverage on a shift basis, so that there is an in-house Physician twenty-four hours a day, seven days a week.

The postoperative wound care that was provided at the Center was in accordance with the post-operative instructions of the surgeon who performed the procedure at the UIC (use wheelchair, no weight bearing, foot soaks, dressings and ointment). According to the record, the consumer had some difficulties with his crutches post-op, and at times refused to wear the surgical boot that had been prescribed to protect his foot.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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."

Although the consumer was properly correct that there might have been something wrong with the wound by May 2nd, there was no clinical evidence of any overt infective process, per the medical documentation, at that time. It was not until May 3rd when clear evidence of an abscess was noted and that a substantial infective process was documented. Although it seems clear why the consumer might have felt that the care was inappropriate (because there was something going on with the wound site), there is nothing in the chart that would show that the Physicians had any reason to suspect that an infection was present prior to May 3rd, 2008.

Allegation: staff members determined that the consumer needed an escort to pick up packages at the security office without cause.

Findings

According to Center personnel, regular mail is delivered to the consumers on the unit. When a consumer receives a package, the package must be opened in the presence of a Security Officer. This allows the Officer to check the contents for contraband.

According to the consumer, on this occasion the consumer, along with another consumer, were having their mail packages checked by security. There was no problem with the consumer's package, but when the contents of the other consumer's package were examined, the Officer determined that it was contraband. It was, according to the consumer, a small change purse that had a metal zipper. The consumer objected to the Officer's assessment that the change purse was contraband and expressed this to him - calmly. The consumer offered that he felt that the whole thing was no big deal, and that he attached no undue attention to it. The consumer stated that the STA talked about his need to stay out of others' business all the way back to the unit.

According to chart documentation from the STA, when the purse was confiscated, the consumer stated that there is no such rule. Security stated that there was a rule and it was documented that the consumer gave security a "hard time". The STA then explained the incident to a Nurse who documented that the "consumer had an argument with security and refused to be redirected by Pinel staff. He kept telling [the other consumer] to check his rights and what is contraband. He then stayed argumentative all the way back to the unit." The Nurse then talked to the consumer, saying that some of the men here are quite sick and that the consumer could have caused an escalation of anger. The RN documented that she told him that he should have addressed this issue by talking to his case manager and not expressing to security “what he feels are the rights of his peers”. She recounts that the consumer said “OK” in agreement with this. The consumer reported that what he was saying to Security was just his opinion.

At a subsequent team meeting which the consumer did not attend, it was determined that the client would be escorted separately to the mailroom, after the other consumers had been processed, to receive his mail packages. This restriction has been subsequently removed without further incident.

According to the STA who was present at the time that the packages were inspected, she felt that the consumer was interfering with the Officer. She stated that the interference was so much so that the Officer called for a second Officer to support him. According to the STA, the consumer was very upset, and talked at length about it as they returned to the unit. The HRA spoke with the Chief of Security without a prior appointment and the HRA acknowledges his full cooperation. He was not familiar with all of the details of the complaint. He explained the institutional concerns regarding contraband material and the need to maintain appropriate security. The Chief did offer that no incident report had been generated by the security staff with regard to this event. He agreed that, had another officer been called for assistance, such a report would most likely have been generated.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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."

The consumer's version of this event is clearly at variance with the recollection of the STA and her record of it at the time. There is a subsequent entry by an RN where she spoke to the consumer regarding this incident.

The HRA cannot discount the consumer's claim; however evidence does not support the allegation that a right was violated.

RESPONSE

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

Pat Quinn, *Governor*

Illinois Department of Human Services

Carol L. Adams, Ph.D., *Secretary*

Division of Mental Health - Region 2
Elgin Mental Health Center — Singer Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

February 2, 2009

Mr. Dan Haligas - Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #09-100-9006

Dear Mr. Haligas:

Thank you for your recent review dated 01/07/09. Per your findings, there were no substantiated allegations. As always, the Facility's goal is to maintain the highest quality of care for our consumers. Please include a copy of our response with any public documents.

Respectfully,

Tajudeen Ibrahim, BA
Acting Hospital Administrator

TI/JP/aw

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