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REPORT OF FINDINGS
TINLEY PARK MENTAL HEALTH CENTER— 11-040-9012
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding the allegations that were 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 allegations concerning Tinley Park Mental Health Center, a state-operated facility. The complaint stated that a recipient was not provided with adequate care concerning pain. The complaint alleged that the unit staff were rude and uncaring especially when the recipient would ask for ice water. It was reported that staff were also verbally abusive to other recipients and called them "crazies." If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Illinois Administrative Code for state-operated facilities (59 Ill. Admin. Code 112.30).

METHODOLOGY

To pursue the investigation, the Manager of Quality Improvement, the Recovery Specialist, a Register Nurse and two Mental Health Technicians were interviewed. The recipient's record was reviewed with her written consent. Relevant facility policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the recipient requested medication for her pain that had been ordered twice daily. A nurse asked the recipient why she did not request the medication from a nurse on the previous shift and delayed administering the muscle relaxing medication for almost two hours. The same nurse allegedly made the recipient wait three hours for her pain medication on a different day. It was reported that the unit staff were rude, uncaring and verbally abusive toward the recipient and other patients. For example, the recipient was told that the nurse was too busy and that she would have to wait. A staff person on the morning shift never gave the recipient ice water as requested. A staff person on the evening shift reportedly told the recipient to get the ice water herself although the ice is kept behind the nurse's station. The staff would

rudely ask the recipient for her headset. Additionally, it was alleged that three staff members were verbally abusive and called other recipients "crazies."

FINDINGS

According to the record, the recipient was transferred to the facility from a community hospital on April 12th, 2011 because she had allegedly taken an overdose of pills with the intention of killing herself. She told the staff that she had taken an overdose of pills because of physical and emotional pain. She reported having surgery on her back area several times and had discontinued taking certain medications prescribed for pain in December 2010. She reported having constant pain in her lower back area, sometimes pain in her neck, and felt anxious and depressed. She rated her pain as an "8" on a scale of "10" being the highest number. It was recorded that she had previously used Vicodin and Xanax to relieve the pain. And, she wanted to discontinue using Xanax because she was addicted to the medication.

The recipient was diagnosed with Major Depression Recurrent, Anxiety, Benzodiazepine Abuse, Chronic Back Pain, Hypertension and High Cholesterol. Her medication regimen included Effexor XR 150 mg daily for depression, Clonazepam 1 mg twice daily and Lorazepam 1 mg every eight hours as needed (PRN) for anxiety, Pregabalin 75 mg twice daily and Ibuprofen 800 mg every eight hours as needed for pain, and medications for her physical problems. The "Initial Nursing Treatment Plan" documented that the recipient's pain level would be rated before and after the administration of pain medication. On April 16th, Methocarbamol, a muscle relaxant 500 mg as needed was ordered, and the medication frequency was changed to three times daily as needed two days later. On the 26th, Methocarbamol 500 mg and Ibuprofen 400 mg twice daily were ordered, and the muscle relaxant medication as needed was discontinued.

A history and physical assessment, completed on April 13th, documented that the recipient did not have any limitation in moving her neck although she reported having pain in this area sometimes. During the assessment, she did not have tenderness in her back area, but she had severe pain when her leg was lifted straight up into the air. She rated her pain as being a "9". The Master Treatment Plan dated on April 15th repeated that the recipient's pain would be rated before and after the administration of pain medication. According to Medication Administration Records, all dosages of scheduled medications were given as ordered, except for Pregabalin. The medication record indicated that nightly dosages of the medication were not offered on April 14th and the 21st. Documentation indicated that as needed medication was administrated many times with one hour follow-up assessments of effectiveness. On April 27th, 2011, the recipient was discharged from the facility with a two week supply of medication.

When the complaint was discussed with Tinley's staff, the HRA was informed that there are one or two nurses on every shift. The nurse who allegedly delayed administering pain medication said that she had counseled the recipient on how to manage her pain and to cope with her problems. She said that the recipient was use to taking Xanax and Vicodin for pain, but the facility does not carry the latter medication. She recalled administering scheduled and as needed medication to the recipient. She explained that there is a two hour window for administering scheduled medication. A pain assessment is no longer done when the medication is changed from as needed to scheduled dosages. According to the nurse, the recipient sometimes refused to

use a wheelchair to take the pressure off her back. She said that her responsibilities include "waiting on patients," but she did not remember the recipient asking her for ice water.

The investigation team was told that there are usually five Mental Health Technicians (MHTs) to every 23 recipients on the unit. A MHT remembered the recipient after she viewed her picture in the record. She said that the recipient complained of having pain in her back area. She had a wheelchair, but she did not always use it. She said that her duties include helping and monitoring patients. The recipient reportedly was offered a couple of blankets because she said that her bed was too hard. She later reported that the blankets were somewhat helpful, but her medications were not effective. The female MHT further explained that recipients would have to ask for ice because the machine is located on the east side of the nursing station (between the east and west nursing stations). She said that the staff usually would get several cups of ice from the machine at a time and cover them with paper towels and then place 10 or 15 cups of ice on the counter for recipients. The investigation team was told that large coolers with ice water are available on the unit and, water pitchers and disposable cups are available at the nursing station. A male MHT told the HRA that ice water is not a problem on the unit. He explained that usually six or seven cups of ice are placed on the counter if one patient requests ice. He said that sometimes the staff must go to the second floor if the ice machine on the unit is broken. He speculated that his last training on abuse and neglect was in 2011. The female MHT and the nurse were reportedly trained on this issue in 2011.

In regard to verbal abuse, the nurse said that calling patients derogatory names or using this kind of language is not part of her character. According to the female MHT, she has never referred to patients as being "crazy" and tries not to use that word. She reported that she has never heard other staff members calling patients "crazies." She said that she would pull the staff person aside and explain that you should talk to people the way you would want them to talk to you, if a staff person was ever verbally abusive in her presence. According to the male MHT, he might refer to patients as being "psychotic," but there is no such thing as "crazy," just people who have problems. And, the staff interviewed reported that patients are allowed to use the facility's headsets, but there are only a limited amount of them available on the unit. They explained that patients can use the headsets for thirty minute intervals, and they can be signed out for an additional thirty minutes if not requested by another patient.

According to the Recovery Specialist, the recipient did not file a written grievance with the facility concerning her care and treatment. She said that sometimes recipients might voice their concerns verbally and complain that the staff are lacking in patience when dealing with them at times. She explained that sometimes recipients might be addicted to certain medication and complain about the physician "weaning" them off the medication. She reportedly had not received any complaints about ice water on the unit. The HRA was informed that the facility's staff receive training on abuse and neglect each year. According to the Manager of Quality Improvement, all appropriate staff had been retrained on the 59 Illinois Administrative Code requirements for reporting possible abuse and neglect because there had been some changes in the rules. She said that the staff also had reviewed the facility's internal policies regarding this issue.

The investigation team interviewed some of the unit recipients privately concerning possible abuse and neglect. One recipient reported that the staff are profane, hostile and usually ignore patients. She said that "the way the staff reply or make you wait or ignore you" is the problem. She reported that a staff person had sent a memo to the unit staff because patients had complained during a "Rights and Responsibilities" meeting about the staff. She provided the HRA with names of three staff members who allegedly had been discussed at the above meeting. We noticed that the nurse identified in the complaint was mentioned. The recipient further alleged that another staff person told her that all of the unit staff had been reprimanded after the meeting. A second recipient told the investigation team that the staff say they help patients but then ignore them. A third recipient who had recently been admitted to the facility said that the physicians are nice but some of the nurses were not. A fourth recipient reported that the staff treats her okay overall. Then, she said that staff does not have time to make calls for her that involves dialing the number on the facility's phone and transferring the call to the pay phone. She stated that the staff on the second shift is the "worst."

Tinley's "Pain Assessment/Reassessment and Management" policy states that all patients will receive pain management through appropriate assessments. A pain assessment will be completed on every patient. The initial pain assessment will be done by the Intake Nurse. The unit nurse is responsible for documenting pain different from that previously reported.

According to Tinley's "Assessment of Patient Needs" policy, each patient who presents to the facility for services shall receive a comprehensive, multi-disciplinary assessment that identifies 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 assessment focuses on the emotional, physical, cognitive, social, cultural and spiritual dimensions. 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 Functional Screening is done that includes a nutritional screening. The unit psychiatrist must interview the recipient and complete a psychiatric evaluation within 72 hours. The Medical Specialist completes a nutritional screening within 24 hours of admission. An order will be written if determined that a full assessment is needed, which is then completed by the dietitian. A social investigation and the Master Treatment Plan must also be done within the 72 hour timeframe. The unit psychiatrist reviews all completed assessments, and this information will be discussed with the treatment team. The integrated information including input from the patient and family determines the priorities of care in the Master Treatment Plan.

Tinley's "Reporting Abuse/Neglect Allegations" policy defines mental abuse as the use of demeaning, intimidating, threatening words, gestures or other actions by an employee toward an individual and in the presence of others that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present. The policy also has procedures for reporting abuse and neglect.

The facility's "Consumer's Rights and Responsibilities" statement includes the right to be free from abuse and neglect. It states that each consumer shall be provided with adequate and humane care and treatment that is Recovery Focused and Consumer-Centered.

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….

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

Section 5/2-112 of the Code states that every recipient of services in a mental health facility shall be free from abuse and neglect.

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.

Based on the record, the facility completed the comprehensive physical examination and psychiatric evaluation within 24 hours in accordance with Section 112.30 of the 59 Illinois Administrative Code even though the Code's Section 5/3-205.5 allows 72 hours. The Authority found no evidence that a nurse delayed administering Methocarbamol (a muscle relaxing medication) as alleged in the complaint. The medication had been ordered as needed for pain. However, the HRA finds that the facility failed to provide adequate medical care because Tinley's nursing staff did not follow the physician's orders regarding the administration of Pregabalin twice daily for pain. The medication record indicated that nightly dosages of the medication were not offered on April 14th and the 21st.

The complaint that a recipient was not provided with adequate care concerning pain is substantiated. This violates Section 5/2-102 (a) of the Code and the facility's "Consumer's Rights and Responsibilities" statement regarding adequate and humane care and treatment. No violations of the facility's "Pain Assessment/Reassessment and Management" or "Assessment of Patient Needs" policies were found.

The Authority cannot substantiate the complaint that the unit staff were rude and uncaring toward the recipient. However, based on statements from recipients interviewed, the staff were sometimes rude and unwilling to help them. This violates Section 5/2-112 of the Code and the facility's "Consumer's Rights and Responsibilities" statement regarding the right to be free from abuse and neglect.

RECOMMENDATIONS

1. The nursing staff shall 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 ""Consumer's Rights and Responsibilities" statement regarding adequate and humane care and treatment.

2. The Authority concludes that the unit staff failed to provide respect in regard to service delivery. Tinley shall ensure that Section 5/2-112 of the Code and the facility's "Consumer's Rights and Responsibilities" statement regarding the right to be free from abuse and neglect are followed.