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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
Case #12-110-9006

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Chester Mental Health Center:

Recipients at Chester Mental health Center have not been treated in a respectful manner.

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and facility policies.

Chester Mental Health Center is a 240-bed, secure, inpatient mental health facility operated by the Illinois Department of Human Services and located in Chester, Illinois.

To investigate the allegation, an HRA team met with the facility administrator, a representative of the facility's internal human rights committee and facility recipients, reviewed a complaint presented to the internal human rights committee and related correspondence, reviewed recipient correspondence and reviewed pertinent facility policies and forms.

COMPLAINT STATEMENT

According to the complaint statement, a nurse on Unit E yells out recipient names during medication pass in a rude, unprofessional and inappropriate manner even when the recipient is standing in front of her. The complaint also stated that a report was made to the nurse's supervisor and the yelling stopped for a short period of time but commenced again.

FINDINGS

A recipient letter dated 09-23-11 stated that a nurse "…continues to shout out the names of patients for 12:00 p.m. medication, right in front of me from the inside of the nurse's cage --as if I was deaf!!! [The human rights committee chair] already knows about it and so does [the nurse's] supervisor. [The nurse's] outbursts have been very unnecessary!!!! They are totally uncalled for!!!!" When an HRA team attempted to follow-up with the recipient, it was told that the recipient had been transferred out of the facility.

The chair of the facility's internal human rights committee verified receipt of the complaint and indicated that the complaint had been addressed by speaking with the nurse's supervisor who addressed the matter with the nurse. The chair also provided information about guiding principles for staff to patient interactions. According to the chair, staff are educated on recipient rights and are expected to honor those rights. Staff are trained in Crisis Prevention Institute approaches in which nonviolent interventions are used to deescalate crises or aggressive behaviors. The facility maintains a Consumer Advisory Council which is a recipient driven committee that meets weekly and is comprised of representatives from each unit. It provides a forum for recipients to voice problems. The chair stated that "this group is well respected and their input is sought by staff and committees on many decisions and it has been instrumental in empowering the patients to make decisions about their care and being an interactive partner with staff." The chair indicated that the Council developed a video that describes what it is like to be a patient at the facility; the video was shown to all staff upon completion and is shown to newly hired staff as part of orientation. The chair also reported that the units hold daily meetings which provide another opportunity for recipients to interact with staff regarding any concerns or issues.

The HRA team examined a September 6, 2011 memorandum addressed to a recipient from the facility human rights committee. The memorandum stated that the committee was "…in receipt of your complaint in which you allege that your rights have been violated; 1) Patient alleges that the nurse [nurse's name] is yelling unnecessarily of patients names for medication…After further review of the above allegation, this issue was addressed. With this information the HREC [Human Rights/Ethics Committee] has determined this complaint resolved." The memorandum concluded by providing contact information for the Guardianship and Advocacy Commission if the recipient still believes his rights were violated. There was no written explanation of what specifically was done to resolve the issue.

On February 23, 2012, the HRA team returned to the facility and met with a recipient who resides on the same unit as the recipient who initially reported the allegation regarding the nurse in a letter dated 09-23-11. The HRA team inquired as to how things were going on the recipient's unit without identifying any specific issue, the recipient immediately reported concerns regarding the nurse named in the other recipient's 09-23-11 statement indicating that she does not want to hear about recipient medical issues, has a "bad attitude," "sits in cage combing her hair," and "yells and screams" at recipients. The complaints were reported to the chair of the facility's human rights committee, the facility administrator and the Office of the Inspector General. The HRA later received a letter on February 29, 2012 from the recipient interviewed on February 23, 2012 that was also signed by another recipient. The letter again named the same nurse stating that she has "…been vary [sic] foul not doing her job has been a [sic] fault giving prns [as needed medication] to all the patients and not letting them go to breakfast, make the [sic] stand by the wall for no reason at all giving them hot water, balling fists at the [sic] slapping them, spitting in the water. These things need to stop immediately." The letter was reported to the Office of the Inspector General.

The HRA examined policies related to the allegation. The facility maintains a code of conduct that includes guiding principals for staff behavior toward recipients indicated that all patients are to "…be treated with dignity, respect and courtesy….Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors." The policy defines

"harassment" as "…verbal or physical conduct that denigrates or shows hostility or aversion toward and individual…" Improper language is also defined and it "…includes vulgar, profane or loud/disruptive language." Both of these behaviors as well as other identified behaviors are considered to be behaviors for which the facility has zero tolerance. All employees are required to report such behavior to his/her immediate supervisor and the supervisor is to report the matter to the hospital administrator. Furthermore, the policy dictates that "Progressive disciplinary action will be instituted for persons found guilty of failure to follow the hospital's code of conduct policy. These incidents may result in disciplinary action, up to and including discharge."

The facility also maintains a policy governing abuse and neglect incidents in which "mental abuse" is defined as "The use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about an individual and in the presences of an individual or individuals that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any individual present." The policy then provides guidelines for reporting and investigating abuse and neglect allegations.

The HRA team examined a complaint form available on the units on which recipients can document complaint incidents and witnesses. The complaint form indicates that it is to be forwarded to the human rights committee and the quality assessment/improvement office.

Finally, the HRA examined documents related to the Consumer Advisory Council. A sample letter indicates that recipients are recommended to serve on the Council "…to represent the patients on your unit and to share your perspective in discussions related to the quality of patient care at Chester Mental Health Center. The Consumer Advisory Council meets weekly on Wednesdays at 3:15 p.m. in the Rehab Department. I have enclosed a set of rules that council members are expected to follow." The letter is signed by the Quality Assessment and Improvement Director and a copy is sent to the recipient's Coordinating Therapist. The accompanying set of Consumer Advisory Council Rules include the following instructions: be courteous; no loud talking/cursing; ensure all have a chance to talk; be honest and thoughtful; if angry, tell the group; be respectful and don't use the names of other people in the group outside of the group; and, try to avoid personal issues as the committee goal is to work on facility wide patient issues.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) requires in section 5/2-102 (a) that "A recipient of services shall be provided with adequate and humane care and services…." Furthermore, section 5/2-112 states that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Abuse is defined in section 5/1-101.1 as "…any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means."

CONCLUSION

The complaint states that recipients at Chester Mental health Center have not been treated in a respectful manner. A specific nurse on Unit E was named and was initially described as yelling and being rude and unprofessional during medication passes. Later reports described the same nurse as having "a bad attitude" with yelling, screaming and other behaviors. The recipient who initially reported the incident to the HRA did so after reporting the matter to the facility's internal human rights committee and receiving a response from the committee that the matter had been resolved; however, the recipient reported that the nurse's demeanor continued. While the recipient eventually transferred out of the facility, two other recipients came forward and made similar reports to the HRA, verbally and in writing.

The facility maintains a staff code of conduct that prohibits the behaviors described by the recipients. The HRA commends the facility for its various avenues in which recipients can voice concerns, including the use of complaint forms, contact with the internal human rights committee, contact with the consumer advisory committee, and access to external advocacy resources, including the HRA. Still, complaints regarding a specific nurse continue.

Based on the corroborating written and verbal reports from more than one recipient, the HRA substantiates the allegation that recipients at Chester Mental health Center have not been treated in a respectful manner. The HRA contends that the complaint violates the facility's code of conduct for staff. With regard to Mental Health Code protections concerning abuse, the HRA defers to the entity responsible for investigating and determining abuse, the Office of Inspector General.

The HRA recommends the following:

1. **Ensure that staff, including the nurse identified in this case, follow the facility code of conduct.**

2. **Reeducate the nurse on the code of conduct and provide the HRA with evidence of the reeducation.**

The HRA also suggests the following:

1. Review the available complaint mechanisms used by recipients to ensure effectiveness. Consider additional means of measuring quality assurance and securing recipient feedback such as follow-ups on complaints reported to the internal human rights committee, the use of surveys, etc.

2. The HRA is concerned that if more than one recipient has observed the nurse's behavior that other staff may have observed as well. The HRA strongly suggests that all staff be reminded of their responsibility to report staff who may be violating the code of conduct or abuse protections.