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Egyptian Regional Human Rights Authority
Report of Findings
Case #12-110-9007
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA) accepted for investigation the following allegations concerning Chester Mental Health Center:

1. A recipient at Chester Mental Health Center has not been provided with adequate care for a medical condition.

2. Staff members have spoken to the recipient in a derogative manner.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds.

To investigate the allegations, an HRA team interviewed a recipient of services as well as facility staff. With recipient consent, the HRA team examined a recipient's record. The HRA also examined pertinent facility policies.

COMPLAINT STATEMENT

According to the complaint, a recipient has generalized pain and soreness throughout his body as well as sores on his feet. However, the facility is reportedly not addressing his pain or the sores. In addition, the complaint states that facility staff call him names using racial slurs which was reported to the Illinois Department of Human Services' Office of Inspector General (OIG).

FINDINGS

Interviews
The HRA team spoke with the recipient in this case who stated that he has pain for which he receives no treatment or medication. He also reported concerns regarding sores on his feet which the HRA team shared with a representative of the facility's internal human rights committee. At a later visit with the recipient, the recipient reported he received some cream for his feet and his foot condition had improved. With regard to the racial slurs, the recipient reported that staff have used racial slurs in speaking with him and confirmed that he had spoken with a

representative of the OIG; he was not aware of the outcome of the OIG's investigation. The recipient identified two witnesses who he stated overheard staff using racial slurs against him; however, one witness was not found at the facility and the other informed the HRA team he had not heard racial slurs against the recipient.

In response to HRA inquiries about staff policy and training related to staff to patient interactions, the Chair of the facility's internal human rights committee stated that staff/patient relations are addressed in numerous ways. The patient handbook outlines patient rights and staff are expected to ensure that recipient rights are protected. Staff training is the primary means of promoting appropriate interactions and facilitating recipient rights as per the Chair. Upon hire, staff receive CPI (Crisis Prevention Institute) training which teaches non-violent means of intervening with behavioral crises. A Consumer Advisory Council (CAC), consisting of Chester recipients representative of all units, meets weekly and serves as a forum to address and resolve recipient concerns. According to the Chair, the work of the CAC "…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 stated that the CAC created "…a video for staff that was shown to all current staff upon completion and is shown to all new hires. This video explains what it is like to be a patient here and their expectations for staff." Training on mental health diagnoses is also provided to assist direct care staff, in particular, with their understanding of mental health needs and patient perspectives. Specialized training may also be given on unique diagnoses or for units that house recipients with more challenging needs. Besides the CAC meetings, units hold module meetings to provide opportunities for staff and patient interactions and to review concerns or other unit issues. The Chair emphasized that recovery and hope are driving forces in the provision of mental health treatment at the facility.

Record Review

With the recipient's written consent, the HRA team reviewed the recipient's record. According to the recipient's most recent treatment plan, dated 11-16-11, the recipient arrived at the facility as an emergency admission from another state-operated facility on 08-12-11. His status became involuntary effective 08-24-11 and his involuntarily commitment status was continued on 11-2-11. The recipient participated in his treatment plan meeting. According to the treatment plan, in the prior two weeks the recipient was aggressive toward a peer on 11-01-11, made repeated threats of violence toward staff and peers on 10-29-11, incited peers to riot on 10-29-11, and became agitated and "racially offensive" toward staff on 11-11-11. The treatment plan also references the use of full leather restraints on at least 2 occasions and multiple PRN (as needed) medication administrations. It appears from the treatment plan that the recipient periodically refuses some medications. The treatment plan also stated that the recipient makes "…outrageous accusations of being victimized and persecuted by Chester staff because of his race…." His physician intends to file a petition for enforced medication due to unpredictable and dangerous behaviors. The recipient has diagnoses of Schizoaffective Disorder, Bipolar Type, Polysubstance Dependence by history, Antisocial Personality Disorder, history of Cellulitis of both legs, Questionable history of Seizures Disorder and a history of Hypertension. The treatment plan lists the following problems: aggression and impulsivity; psychosis; Mood Disorder; history of asthma; and, problems with bowel elimination, skin integrity, Seizure Disorder and Hyperlipidemia. The recipient takes medication for psychosis, mood stabilization,

insomnia, anxiety and agitation. The treatment plan noted that the recipient is paranoid which triggers aggression and uses "the race card" to refuse treatment interventions; behavioral programming is not expected to be effective until his psychiatric symptoms are stabilized via medication. The recipient meets twice per week with his therapist and activity participation is encouraged. With regard to medical concerns, the treatment plan stated that the recipient's asthma, hypertension, constipation and skin are to be monitored by nursing staff; staff will educate the recipient on his medical issues and medication will be prescribed as needed. The recipient's skin condition on his feet is specifically addressed in the treatment plan although reference to general pain is not.

The HRA examined medication orders dating back to the recipient's admission through December 3, 2011. An order on 08-12-11 included acetaminophen for pain, milk of magnesium for constipation and an inhaler for asthma. The recipient's skin condition on his feet was identified on 08-17-11 at which time foot soaks and a topical cream were ordered. General complaints of pain were documented by the physician on 08-17-11 along with notes that the recipient refused to be examined; however, lab work was ordered in reference to complaints of pain and every three months thereafter. Cholesterol medication was ordered on 08-18-11. Acetaminophen was ordered to be continued on 09-07-11 along with medication for constipation and asthma which were renewed every 30 days. A heart healthy diet with increased calories was ordered on 10-03-11. Shower shoes were ordered on 10-17-11. Another foot cream was ordered on 10-17-11 and again on 11-01-11. Medication for allergies was ordered on 11-24-11.

The HRA also examined all progress notes beginning at admission through 12-06-11. Notes were completed by nurses, the recipient's therapist, the physician, aides, etc. The HRA found multiple notes of the recipient complaining of generalized pain, being offered a pain reliever and then monitoring by nursing staff to ensure pain relief. Nursing staff would ask the recipient to rate his pain on a scale of 1 to 10 and then returned after pain medication was administered to verify that the recipient's pain rate decreased. In addition, the notes documented the provision of creams and foot soaks for the skin condition on the recipient's feet. When labs indicated an elevated cholesterol level, the recipient was placed on a heart healthy diet, prescribed medication and provided with education regarding cholesterol levels. When the recipient complained of a sore throat, checks were done and medication was prescribed.

Progress notes also documented the recipient's repeated accusations of racial slurs which were referenced by professional staff as racial preoccupation associated with paranoia. On several occasions the accusations were made after the recipient was placed in restraints or put in seclusion after incidents of aggression toward staff and peers. Sometimes, the accusations were made against peers - one time when a ball hit the recipient during a recreational activity. On a few occasions, documentation stated that the recipient attempted to "rile" other recipients into fights with "white" staff. On other occasions, the documentation stated that the recipient made racial slurs against others. Documentation also indicated that the paranoia and associated accusations would likely dissipate given effective medication and treatment. The HRA also found evidence that staff contacted the OIG regarding abuse allegations. And, one note, written by a physician, documents that a physical check was done subsequent to an abuse allegation that indicated no findings of physical abuse.

Policy Review

The facility maintains a policy entitled, "Pain Assessment and Management," in which the primary goal is to ensure recipient access to the "…best level of pain relief that can be safely achieved." Staff are to request recipients to rank pain using a numeric scale and identify the location of the pain as well as related conditions which is to be documented in a recipient's record. Pain medication is to be given as requested and ordered and the pain level is to be reassessed every hour until it is down to a reported pain level of 3. If the pain level does not decrease, a physician is to be notified.

Chester Mental Health Center's Code of Conduct stresses that all patients, employees and visitors be treated with dignity, respect and courtesy with zero tolerance for intimidating or disruptive behaviors, including harassment. Harassment is described as "verbal or physical conduct that denigrates or shows hostility or aversion toward and individual…this includes: epithets, slurs, negative stereotyping, threatening, intimidating, bullying, or hostile act, racial jokes…." All such incidents are to be reported. The facility maintains an additional policy for reporting and investigating abuse allegations.

A sample complaint form available on each unit allows a recipient to document complaints, incidents and any witnesses to incidents; the form is then submitted to the human rights committee and quality assurance department for review and resolution.

The Illinois Department of Human Services' rights form (IL 462-2001) as posted on the agency website includes the right to adequate and humane care and services although the right to be free from abuse is not specifically listed. Also, the rights form includes contact information for the Illinois Guardianship and Advocacy Commission but information on two of the regional Guardianship and Advocacy Commission offices is outdated. The Department's website also includes a discrimination complaint form that lists contact information for the Illinois Department of Human Rights and the U.S. Department of Justice.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states that "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."

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."

CONCLUSIONS

The complaints in this case allege that a recipient was not provided with adequate care for a medical condition and that staff members spoke to the recipient in a derogative manner using racial slurs.

The recipient's record included treatment plan documentation, physician orders and progress notes indicating that the recipient's complaints of pain and concerns regarding the skin condition on his feet were being monitored by medical staff, addressed as goals in the recipient's treatment plan and receiving various forms of treatment regimens as per physician orders. **The complaint that the recipient was not being provided adequate care for a medical condition is not substantiated.**

The record documented repeatedly in progress notes and in the treatment plan the clinical determination that the recipient had a racial preoccupation that resulted in allegations against staff. The OIG was appropriately notified when appropriate. **The HRA did not find evidence that staff spoke to the recipient in a derogative manner using racial slurs, thus, this complaint is not substantiated.**

The HRA does take this opportunity to offer the following suggestions:

1. Offer periodic cultural sensitivity training to both staff and recipients.

2. Notify DHS of the need to update GAC contact information on the recipient rights form.

3. Notify DHS and request that the right to be free from abuse and neglect be included in the DHS rights form.

Comment:
The HRA commends Chester for having a forum in which recipient can discuss concerns through the CAC.