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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 13-030-9013
JOHN J. MADDEN MENTAL HEALTH CENTER

Case summary: The HRA substantiated the complaint that the facility did not follow Code requirements when it did not secure the recipient's belongings, however allegations that the facility did not allow her to see a physician for a diabetes related foot injury, did not give her the prescribed medication for the injury when she was discharged, and did not have a physician examine her when she was ill on the unit are not substantiated.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at John J. Madden Mental Health Center (Madden). It was alleged that the facility did not follow Code requirements when it did not secure the recipient's belongings, did not allow her to see a physician for a diabetes related foot injury, did not give her the prescribed medication for the injury when she was discharged, and did not have a physician examine her when she was ill while on the unit. If substantiated, these would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Madden Mental Health Center is a 151-bed, Illinois Department of Human Services (DHS) facility located in Hines, Illinois.

To review these complaints, the HRA conducted a site visit and interviewed the Medical Director, the Associate Medical Director, the Hospital Administrator, the Director of Security, the Director of Quality Strategies, the Director of Social Work, and the Director of Nursing. Hospital policies were reviewed as well as the recipient's clinical record with written consent.

COMPLAINT SUMMARY

The complaint indicates that the recipient had a number of personal belongings inventoried when she was admitted to Madden, that they were stored on the unit, and that she did not receive them when she was discharged. The complaint shows that the recipient's attorney asked the security staff about the belongings, but they did not know what happened to them.

The complaint alleges that while the recipient was a patient at Madden, she complained about her foot, which was swelling and numb due to high blood pressure and diabetes, however she did not see a doctor for about a month.

The complaint alleges that when the recipient was examined by a doctor for her foot, she was prescribed an ointment, however she was not given this ointment when she was discharged.

The complaint alleges that the recipient complained of being ill during the time she was in treatment but the doctor would not examine her. When she was discharged she immediately went to a hospital where she was diagnosed with a urinary tract infection (UTI).

FINDINGS

The record shows that the recipient was admitted to Madden on 10/26/12. The recipient's Discharge/Transfer Summary, completed 12/05/12, is included in the record and it states, "Patient is a 44 yr old AA mother of two, homeless and unemployed for some time and not getting any funds. Her sole support has been a mother with whom she has limited contact. [The recipient] was admitted as a transfer form [local hospital] where she was identified as Jane Doe and was seen as very confused and not even able to give basic information about self. She was seen the same day in intake but subsequently she was identified as … which also turned out to be incorrect…. On the unit she wanted to know who I was and then came in to talk but seemed to have little understanding of why she was here. She mentioned about how she had two interviews to go to, one for housing, and she had stepped on something and that is why she had gone to ED. However she then wanted to know where her belongings were and did not want to give me any addresses or phone number with comments that she was not sure if they wanted her but that she could tell them herself if allowed but was not able to do so from the public phone. She had an overall gestalt of anger and paranoia and seemed unable to have a clear conversation. Was shown a list of her belongings which she wanted to see right away to confirm if that was true and that we will try to help her figure out what happened that brought her in. She was focused on discharge and was involuntary. We felt comfortable going to court for court commitment if necessary. As we had little to go on we had no clear diagnosis initially. However later on in her stay we were able to get more clarification". The Summary indicates that the recipient was referred to an internist for her medical management and she signed a release to contact her mother. Her mother provided the recipient's correct name, and with this information, staff was able to confirm numerous treatment episodes for the recipient. She was then diagnosed with Schizophrenia and was petitioned for involuntary treatment and medication and the order was secured on 11/08/12.

The record contains the recipient's Initial Psychiatric Nursing Assessment, completed 10/26/12 as well as weekly updates. The Initial Assessment indicates that a belongings search was completed and that the recipient had eye glasses, money, and jewelry and indicates "see property sheet" for other items. In the section indicating the need for immediate medical attention it states, "Pt ankle swollen" and the pain assessment indicates no pain. Weekly nursing updates were completed on the recipient and the updates added on 11/08/12 and 11/15/12 state, "Pt keeps to herself, walks around in the day area holding her belongings in a pillow case,…" The recipient's Treatment Plan Problem List is included in the record and it identifies "feeling

depressed, disoriented and paranoid" and the Medical Problems are identified as "abdominal pain/acid reflux", and "weight loss." The Medication Administration Record indicates that on 11/28/12 the physician ordered Eucerin cream to be applied twice daily "for feet and dry skin." There is no mention in the Nursing Progress Notes, Nursing Updates, or other Notes that the recipient complained of pain or other ailments or that she requested to see the doctor.

The record contains the recipient's Medical History and Physical Exam completed at admission and it does not indicate any pain or swelling in the ankle or foot. It does indicate Abdominal Pain and Acid Reflux in the Medical Diagnosis section. The recipient was prescribed Prilosec, Milk of Magnesia, and Mylanta for the stomach related issues, and Acetaminophen and Ibuprofen for "pain" (not described).

The recipient's attorney provided the HRA with the recipient's Personal Property Receipt. The receipt indicates items that were placed in the "Trust Fund" and another which is described as "Property retained by or released to the recipient." The Trust Fund items include: 1 cell phone, 1 cigar, 10 plastic cards, 3 pairs of earings, $22, 1 gold charm, 3 rings, 1 white necklace, 1 gold card, 1 white earing, 1 CTA card, 14 keys, and 1 black pouch. The form is not signed by the recipient and does not contain a signature on the line indicating that a copy was provided to the recipient. The property retained by the recipient includes: 1 pair grey pants, 1 black jacket, 1 pair jogging pants, 1 pair black socks, 1 red sweater, 1 black tank top, 1 grey jacket, 1 red bra, 1 pair white socks, 1 pair underwear, 1 pair glasses, 1 hair curler, miscellaneous paper and books, 1 bottle of perfume, miscellaneous coins, 1 pair black slippers, 1 maroon purse, 1 black hair brush, 1 red bandana, 1 black skull cap, 1 red blouse, 1 red pair of pants, 1 black wig, and 1 white top. This form has the recipient's signature at the bottom, however it does not contain a signature on the line indicating that a copy was given to the recipient. The form has an area indicating "Date received" and "Date released" for each item. The form does not indicate that items are released to the recipient.

The record contains a Trust Fund Deposit Authorization form. It indicates that a "Jane Doe" (recipient's name had not been known at this time) has deposited $22 on 10/26/12. The form is initialed by the recipient and signed by staff.

Progress Notes from 10/27/12 indicate that the recipient was escorted by security to Pavilion 2 "with all her belongings." Notes from 10/27/12 state, "…Pt up at nurses' station window demanding items that have either already been given to her or locked up in Trust Fund." Again the next day another entry states, "Repeatedly asking for her personal property…" On 11/03/12 Nursing Notes state, "It was brought to attention of staff that the patient was keeping the video cassettes in pillow case and her room. Staff retrieved the videos from the patient and endorsed to the other shifts not to keep any extra videos in the dayroom." Progress Note entries for each day mention that the recipient continued to carry her belongings with her in a pillow case through 11/11/12.

The recipient's attorney also provided an Incident Report, completed by the recipient, that was initiated on 12/06/12. The nature of the incident is identified as "Lost Property." The description of the event states, "I describe to the officer that 1 real ring is missing (1 diamond w ring), red luggage purse is missing 2 piece red jump suit is missing a white blouse, a pair of

eyeglasses, a pair of black socks, a red bandana. For weeks complained how that the person was unable to verify that she received my belongings in trust funds and belongings and other things. 2 other attempts was didn't verify she had any knowledge of my things never talk to anyone but my mother and other person and she denied my bus transportation. I told the people and they didn't listen they owe me the lawyer said they have a lot of money over there I hope she was talking about me…" The report is stamped as having been received by Security, however there is no indication on the Incident Report or from staff report, that any action was taken on the complaint.

Progress Notes from 12/07/12 state, "Patient is discharged per order. Discharge medications given with instructions. Aftercare plans explained. TF [trust fund] and all other belongings given to patient. Verbalized understanding. Patient is alert and oriented x 3."

The recipient's attorney provided documentation from a Chicago area hospital that the recipient went from Madden immediately to an emergency department for dysuria. She was diagnosed with a urinary tract infection and was prescribed Ciproplaxacin (antibacterial specifically for the treatment of UTI) on 12/078/12 for her illness.

FACILITY REPRESENTATIVES' RESPONSE

Facility representatives were interviewed about the complaints. With regard to recipients' property, they stated that recipients' property is inventoried upon Intake. The inventory is copied and one copy remains with the Trust Fund envelope, one copy remains with the belongings which are stored on the unit, and one copy remains in the recipient's record. If a recipient has money or valuables, they are placed in a sealed envelope which is locked in the Trust Fund, and this envelope cannot be opened except by a directive from the Medical Director, and it is picked up by the recipient on the date of discharge. Belongings that remain with the recipient can be placed in a cubby hole, but there is no locked unit except for the storage room on individual units. Staff was asked why the recipient's belongings were allowed to be carried with her during her hospitalization instead of being stored in the locked room and they indicated that staff would not force patients to place their belongings in the storage room unless they presented a danger.

For the recipient in this case, staff indicated that her valuables were listed and stored in the Trust Fund, and the remainder of the recipient's belongings were inventoried and kept by the recipient on the unit. The recipient in this case was not able to sign the property form at admission because she was very disoriented (and remained so throughout her stay). When the recipient was discharged, she signed off on the Trust Fund list that was inventoried upon her admission, however staff indicated that at discharge, staff person probably did not check the recipient's belongings against the list that was completed at Intake.

Staff were asked about the process that followed the recipient's report of lost or stolen items. They indicated that Incident Reports are submitted to Security for a review by a team of staff each day. This team includes the Administrator, the Medical Director, the Associate Medical Director, the Quality Manager, the Director of Nursing, the Director of Social Work, the Safety Officer, and the Chief of Security. The team determines if there is a need for further investigation or referral, or the issue is discussed and resolved on the unit or by the

interdisciplinary team. Staff indicated that they did not think this particular Incident Report was processed, except that it was forwarded to Security and stamped received. Staff indicated that it is not the practice for recipients to complete Incident Reports and that this probably should have been done by staff.

Facility representatives were interviewed regarding the treatment for a diabetes related foot injury. They indicated that the recipient did not have high blood pressure or diabetes and her blood sugar levels and vitals were monitored and recorded throughout her hospitalization. Also, staff reported that the recipient did not complain of foot pain or a foot injury. They indicated that a physician is available 24 hours daily and she would just have to request to see a physician and it would have been arranged. They also indicated that the recipient was thoroughly examined by both a physician and a psychiatric nurse when she was admitted, and there were no medical issues involving her foot or other pain. Staff also stated that since it is very often the case that mental health patients do not get the help they need with medical problems due to their mental health issues, Madden makes every attempt to address each medical concern to ensure that their patients receive this care.

Staff were interviewed about the recipient receiving her medication and foot cream when she was discharged. They indicated that she received her medication as was recorded in the notes on that day (however Madden policy indicates that prescriptions will not be given to patients upon discharge, but the order will be forwarded to the referral placement). Additionally, the foot cream was not prescribed for a foot injury, but rather was prescribed for dry skin, and could easily be purchased over the counter. Staff believe the foot cream was given to the recipient upon discharge along with her other medications, as noted in the progress notes.

Staff were asked about the complaint that the recipient was ill while on the unit. Staff indicated that the recipient did not report any illness and did not exhibit any behaviors which would indicate an illness during her hospitalization, except for the acid reflux and abdominal pain, for which she was treated.

STATUTES

The Mental Health Code states that, "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess, and use personal property and shall be provided with reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section [to protect the recipient or others from harm]…. When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful property which is in the custody of the facility shall be returned to him" (405 ILCS 5/2-104).

The Mental Health and Developmental Disabilities Code 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" (405 ILCS 5/2-102 a). Adequate and humane services are described as "…services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others" (405 ILCS 5/1-101.2). Section 3-205.5 of the Code indicates that

within 72 hours after admission the facility must provide or arrange for a comprehensive physical, mental and social investigation of the recipient. Additionally, in section 3-209 the Code mandates that within three days of admission a treatment plan must be prepared which includes an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of service, a timetable for their completion, and the designation of a qualified professional responsible for the implementation of the plan. Also, the plan must be reviewed and updated as the recipient's condition warrants, but not less than every 30 days.

The Department of Human Services Administrative Code (59 Il. Admin. Code 112.30) states that each person admitted to the Department shall have a thorough physical examination within 24 hours after admission and annually thereafter. The Code states that on completion of the comprehensive diagnostic examinations, a treatment plan for any medical or dental services shall be established as part of the recipient's individualized services plan.

FACILITY POLICY

Madden provided their Policy and Procedure for Patient Property (No. 200 Patient Rights Specific) states that patients' personal property will be secured in a locked area until it is returned to the patient at discharge. The first action regarding property begins at Intake:

"1. Two nursing staff shall prepare a complete and itemized Personal Property form DMHDD-1 for each admitted patient in the presence of the patient. All patient property shall be listed as being sent to either Storage, Pharmacy, Trust Fund, kept by the patient, or sent to the pavilion with staff.

2. For valuables to be deposited in the Trust Fund, the Nursing Staff at Intake must use a valuables bag from security. The Intake Staff are to enter the number of the envelope on the Madden MHC Property log along with the patient's name, and initials of the staff filling out the log.

3. All personal property or the absence thereof, shall be listed on a "Personal Property receipt" form, prepared in triplicate. All valuables are to be placed in the security valuables bag and sealed. The patient will receive a copy of DMHDD1 and the original valuables envelope numbered receipt. The original DMHDD1 and the numbered valuable trust fund envelope shall be inserted in the clear outer pocket of the security valuable bag and sealed immediately. The security bag will then be immediately deposited in the valuables depository box on the Intake unit.

4. The patient's valuables will be picked up by the Business Office the next business day. If any part of the property is returned to the patient or given to a relative or other authorized person, it shall be signed for by both the person issuing the property and the patient, or authorized person receiving the property.

5. One copy of the form DMHDD 1 shall be given to the patient.

6. A third copy will be placed in the patient's chart with the numbered property stub."

Once on the pavilion:

"1. Nursing staff shall document on a new Patient Property Clothing form (DMHDD 1) any additional patient property received while the patient is residing on the pavilion and place the form in the patient's clinical record.

2. In event of a complaint of lost/stolen patient property, the pavilion staff shall complete an Unusual Activity Report, and attach a copy of the DMHDD 1 form and forward these reports to Security.

3. Nursing will notify Business Office each morning of anticipated discharges for the day.

4. Prior to discharge of the patient the Charge Nurse will assign a Mental Health Technician to gather the patient's belongings on the pavilion and from the Storage Room and Pharmacy. A Mental Health Technician will escort those patients who have been identified by the treatment team as requiring escort to obtain property from Trust Fund (if applicable). Unit or administrative staff may pick up patient property if the patient is unable to leave his unit."

For Trust Fund belongings:

"1. The Trust Fund Staff will empty the trust fund patient property drop box daily Monday through Friday. On weekends and holidays the patient property drop box will be emptied on the first following business day. The trust fund staff must immediately report to the Nursing Supervisor or AOD any suspected tampering or skip in sequential numbers.

2. The patient property envelopes will be taken to the Business Office and placed in the property vault. Once in the Business Office the trust Fund staff will log the patient property envelopes into the patient property data base.

3. Any and all discrepancies between items returned to the patient are to be immediately forwarded to the Business Office Administrator or Accountant Supervisor and an incident report filed with all details regarding the discrepancies."

Madden provided their Policy and Procedure for Intake Screening (1500 Assessment and Treatment Planning). This policy indicates that persons admitted from a general hospital or emergency department must have a medical clearance to include a history and physical examination and a statement of the patient's overall physical health. A medical physician will obtain and review this statement, and if necessary obtain a physician to physician report on medically complicated patients to assure medical clearance. Within 24 hours of admission, the Medical History and Physical is completed, which includes a Pain screening from the medical Specialist. Additionally, the Registered Nurse on the unit completes a Nursing Assessment which identifies medical issues as problems to be addressed in the treatment plan.

Madden provided policy for Injury Reporting (1802 Emergencies/Special Treatment). This policy indicates that "As soon as possible following the observation or discovery of an injury, the employee, part-time employee, temporary employee, contractor, subcontractor, employee of a contractor, student or volunteer who discovered the injury shall contact the responsible registered nurse. The registered nurse is to personally assess the injury, as soon as possible following notification that an individual has incurred injury or or has been in a situation with the potential for injury. The nurse shall determine the severity of the injury and provide nursing care as appropriate. If the registered nurse determines that an injury requires medical intervention, a physician shall be notified".

Madden provided policy for Medication Information at Discharge (1500 Assessment and Treatment Planning). It indicates that a complete list of the recipient's medications is communicated to the next provider of services when the recipient is discharged. The community mental health provider is provided with a faxed copy of the Discharge Summary with the discharge medications and dosage. The recipient is also provided a copy of the prescribed medications and dosage to present to the next provider.

CONCLUSION

The clinical record for this recipient indicates that she carried her belongings in a pillow case for the majority of the time she was hospitalized, and continued to express concern for these belongings as well as the items placed in the Trust Fund for the entire time she was hospitalized. Given that the recipient was homeless and that these belongings were all she had to sustain herself, it was critical to her to protect them. Although the items were inventoried upon the recipient's admission, there is no checklist of what was returned to her upon discharge. Additionally, when the recipient reported that her items were lost, staff did not complete the mandated process for investigating the loss, even after the recipient was asked to complete her own Incident Report and it was received by Security. The HRA substantiates the complaint that the facility did not follow Code requirements when it did not secure the recipient's belongings and did not return them to her upon discharge.

The clinical record does not indicate that the recipient requested to see a doctor while she was hospitalized, however the Intake documents do note that she arrived at the facility with a swollen ankle that had caused her to go to an emergency department originally (although it was not related to diabetes, which the recipient did not have). It is not known whether or not she was treated for this ailment while a patient at Madden. She was later prescribed a lotion for dry skin, and this may be the cream that she indicated she did not get at discharge. It is not the policy of the facility to send medications along with recipients at discharge, but to forward their prescriptions to the referring treatment location, but staff indicated in the notes that she was given her medications when she was discharged. Additionally, documented evidence provided by the recipient indicates she suffered from an infection while she was a patient at Madden, however we cannot know if she alerted the nurse or physician about this. The facility does provide around the clock nursing and physician care, and the recipient was examined regularly with no note of complaint, however a urinary tract issue would require the report of the patient, and we cannot confirm that she did this. Without further information the HRA is unable to substantiate that the facility did not allow the recipient to see a physician for a diabetes related

foot injury, did not give her the prescribed medication for the injury when she was discharged, and did not have a physician examine her when she was ill while on the unit.

RECOMMENDATIONS

1. Ensure that recipients' belongings are inventoried, secured, and returned to them upon discharge. Review with staff the process for implementing these steps.

2. Ensure that when recipients report lost belongings the Madden policy and procedure is followed so that staff complete an Incident Report and the incident is investigated.

SUGGESTION

1. It is not clear from the record that the recipient's swollen ankle, which was identified at Intake, was ever evaluated or treated during her hospitalization. Ensure that recommendations that are made are for follow-up are given to physician's for further treatment or evaluation.