

**Bates vs. DHHS**  
**Consent Decree Paragraph 27**  
**Bi-Annual Report: Grievance Filings**  
**July 1, 2008 – December 31, 2008**

As a component of the Bates vs. DHHS Consent Decree Settlement Agreement, DHHS Office of Adult Mental Health Services (OAMHS) is required to report on the numbers of grievances filed within the adult mental system on a semi-annual basis. This report summarizes Level II and Level III Grievances filed from July 1, 2008 to December 31, 2008.

Paragraph 27 of the Settlement Agreement states: “Defendants shall prepare semi-annual reports of all complaints and of all grievances appealed to the Superintendent of AMHI (Riverview), the Director of Bureau of Mental Health (now Office of Adult Mental Health Services) and the Commissioner. Said reports shall summarize the issues raised, findings made, and remedial actions taken, and shall be submitted to the master, counsel for the plaintiff’s and the Office of Advocacy.”

**LEVEL 2 GRIEVANCES**

**Community**

Issue: The Grievant alleged that his guardian was wrongfully restricting his access to community activities, including church and work.

Finding: The Grievant has a documented history of placing himself at risk and posing a threat to young children. The restrictions in place are well considered, reasonable and within the guardian’s authority and responsibilities.

Resolution: No rights violation occurred.

Issue: The Grievant alleged that she was wrongfully restrained and secluded by staff of the Respondent, a hospital and, specifically the hospital’s emergency department.

Finding: The Respondent improperly denied the Grievant a Level 2 appeal for lack of apparent merit. That finding was remanded by the Superior Court upon an 80-C appeal.

Resolution: Allegation substantiated. The Respondent issued a written apology to the Grievant and the parties agreed to provide additional training to hospital staff.

Issue: The Grievant filed collateral grievances against (1) his community mental health services provider and (2) the OAMHS Regional Office. Specific allegations were:

1. That the community mental health services provider:
  - Improperly terminated community integration services;
  - Violated his confidentiality;
  - Failed to respond to his Level 1 Grievance.

2. That the OAMHS Regional Office:

- Denied him participation in the decision to transfer services to a different Intensive Case Manager;
- Denied him Intensive Case Management services while he was incarcerated;
- Violated his confidentiality while he was incarcerated.

Finding: An exhaustive review of the record and the information submitted by the Grievant resulted in a finding that no basis in claim existed for any of the Grievant's allegations.

Resolution: No rights violation occurred. All allegations were dismissed for Lack of Apparent Merit. The Grievant was informed of his right to appeal to Superior Court pursuant to the Maine Rules of Civil Procedure, Rule 80-C.

### **Riverview Psychiatric Center**

One individual filed seven (7) Level 2 Grievances

Issue (1): The Grievant alleged that, contrary to hospital policy, a nurse failed to apply cream to her (the Grievant's) feet.

Finding: The Grievant was capable of applying the cream herself and self-care is a component of her treatment plan. There was no deviation from policy.

Resolution: No rights violation occurred.

Issue (2): The Grievant alleged that she was administered a wrong medication dosage.

Finding: The incident did occur, but was corrected within an hour, consistent with the policy governing medication administration.

Resolution: No rights violation occurred. The Director of Nursing was instructed to address medication variance issues as appropriate.

Issue (3): The Grievant alleged that her psychiatrist discontinued two (2) of her medications without her consent and ordered two new medications without consulting her.

Finding: The decision to discontinue the two medications was clinical. The new medications were offered but not compelled.

Resolution: No rights violation occurred.

Issue (4): The Grievant alleged that a staff member had treated her with disrespect and had been abusive.

Finding: Upon investigation it was determined that no disrespect or abuse occurred. It was found, however, that the therapeutic relationship between the Grievant and her treatment team was "less than optimal."

Resolution: No rights violation occurred. Involved staff and supervisors have been directed to assess the therapeutic relationship and take appropriate steps to improve it to the greatest extent possible.

Issue (5): The Grievant alleged that staff violated her confidentiality.

Finding: Documentation that contained confidential information had been left where staff and patients could have seen it.

Resolution: The allegation was substantiated. Corrective policy measures were enforced.

Issue (6): The Grievant alleged that a nurse attempted to administer her (the Grievant's) medications at the nurses' station where others could potentially overhear any conversation. The Grievant stated that while her confidentiality was not breached, it might have been.

Finding: While no rights violation occurred per se, the potential for breached confidentiality did exist.

Resolution: No rights violation occurred per se. Corrective policy measures were implemented to preclude possible future violations.

Issue (7): The Grievant alleged that staff use of personal cell phones at RPC created the potential for breaches of confidentiality and distracted staff from providing appropriate care and treatment.

Finding: No violation of confidentiality occurred nor were any lapses in care and treatment reported.

Resolution: No rights violation occurred. The issue's potential to adversely impact treatment and confidentiality was addressed. Staff has been "re-instructed on the hospital policy on cell phone use, the importance of attention to client care, and the importance of maintaining client confidentiality at all times."

Six individuals filed single Level 2 grievances.

Issue: The Grievant alleged that staff refused to dispense her medication before 8:00 a.m. despite her obvious immediate need for same.

Finding: Staff acted appropriately according to policy.

Resolution: No rights violation occurred. Staff was directed to dispense medication to the Grievant in a timely manner according to her clinical needs.

Issue: The Grievant alleged that he was being denied the right to have visitors.

Finding: A clinical decision had been made to restrict the Grievant's visitors to family members for a 14 day period, at which time the restriction was to be reviewed.

Resolution: No rights violation occurred.

Issue: The Grievant alleged that her psychiatrist accused her of writing "white supremacist graffiti" on a wall and referred to her as a "white supremacist." She requested a new psychiatrist.

Finding: The psychiatrist reported that his concern was that the graffiti was "disrespectful and destructive to property."

Resolution: No rights violation occurred. The Grievant admitted to writing the graffiti, which she denied was supporting white supremacy. The psychiatrist is the only one assigned to the Grievant's unit. A new psychiatrist was not assigned.

Issue: The Grievant alleged that he was denied the right to review his records by his psychiatrist.

Finding: The grievance was substantiated at Level 2.

Resolution: Allegation substantiated. Pursuant to regulation and policy, the Grievant was given access to specifically requested parts of his records.

Issue: The Grievant alleged that he was placed under a series of psychiatric emergency orders by his psychiatrist. The Grievant further alleged that the psychiatric emergencies were ordered for the sole purpose of creating a record that would ensure his commitment to the hospital.

Finding: The psychiatric emergencies were ordered for cause and in accordance with policy and regulation.

Resolution: No rights violation occurred.

Issue: The Grievant alleged that when he asked why patients were not allowed to visit each other in their rooms, he was told that it was a matter of policy. When he requested a copy of the policy he was informed that none existed.

Finding: It was determined that no policy exists governing patients visiting each other in their rooms. The practice was described as a rule “of etiquette and behavior in society that may not be found in law but never the less most would agree” is an accepted standard of “behavior or practice.”

Resolution: No rights violation occurred.

### **Dorothea Dix Psychiatric Center**

Issue: The Grievant alleged that the hospital failed to provide her with discharge information concerning a patient who had threatened her.

Finding: There was no clinical finding that the discharged patient was dangerous. To provide discharge information to the Grievant would have violated the other’s confidentiality.

Resolution: No rights violation occurred.

### **LEVEL 3 GRIEVANCES**

No Level 3 Grievances were filed during this time period.

## **ASSISTED REFERRALS**

Assisted referrals are comprised of issues that are brought to the attention of OAMHS, either as collateral to a grievance or as distinct issues which the person does not wish to formally grieve. Working with consumers, families and service providers, OAMHS staff has been able to identify and resolve problems. Services and supports have been obtained, restored and/or reconfigured to better meet consumer needs. 36 individuals were provided assistance during the period of July 1, 2008 – December 31, 2008.

### **TOTALS**

Number of Level 2 Grievances: 18

Unduplicated Level 2 Grievances: 11

Responded to Within 5 Days or Extended: 18

Number of Level 2 Grievances Substantiated: 3