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HUMAN RIGHTS AUTHORITY – PEORIA REGION
REPORT OF FINDINGS

Case #20-090-9006
UnityPoint Health-Methodist/Proctor

INTRODUCTION:

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving services at UnityPoint Methodist/Proctor. The allegations are as follows:

1- **Inadequate staff response to patient's request for medication reduction due to side effects.**

2- **Violation of patient's rights demonstrated by the hospital when staff refused to honor patient's request to be seen by a new psychiatrist.**

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100). The facility receives patients statewide, excluding Cook County. There are 23 to 25 staff members, including nurses, mental health technicians, certified nursing assistants (CNA), a recreational therapist, and a psychiatrist. They provide medical and psychiatric services at the facility. Staff estimated between 1500 - 2000 patients present to the emergency department (ED) with mental health needs yearly, with 1700 to 1900 over the past three years. The emergency department has 30,000 overall patients that present yearly. The hospital employs 6 psychiatrists with admitting privileges and one part time psychiatrist without admitting privileges. One psychiatrist is assigned to another hospital. The hospital also has six other–psychiatrists available to consult with patients on the Behavioral Health Unit through another community service and a college. There are 14 Residents who are in their first and second year of medical school that rotate on the behavioral health unit. Some fourth-year residents return to the behavioral health unit as an elective. The behavioral health unit is an inpatient mental health unit with sixty-seven beds. The HRA visited the facility and conducted a site visit interview with representatives involved with this patient's care. The HRA also conducted a patient chart review with authorized written consent.

Complaint Statement

A patient was involuntarily committed with court enforced medications to UnityPoint Healthcare Methodist/Proctor's behavioral health unit where the patient verbalized concerns on the side effects of her medications to staff. The patient reported to staff of feeling overly sedated at nighttime describing it as, "I'm afraid to go to sleep at night because of how I feel on the Haldol." The complaint alleges that the attending psychiatrist was not listening to the patient's medication concerns. The patient also requested a new physician and the hospital will not allow the patient to speak with another doctor.

Interview with staff (01-07-2020)

A meeting was held at UnityPoint Methodist with HRA members and administrative staff from the hospital. The HRA provided a copy of the signed consent to the hospital staff to be able to discuss confidential aspects of the patient's care at the hospital in the ED and the Behavioral Health Unit.

Involuntary Admissions can be a part of the admission process to the Behavioral Health Unit at this hospital. Sometimes the Involuntary Admission also has court enforced medications. The Behavioral Health Unit has a rotation system for Psychiatry staff. UnityPoint Methodist has five attending physicians and then up to 6 "others" who are employed via contract. The unit serves as a rotation for residents who are in years 1 through 4 of medical school to become a licensed medical or psychiatry physicians. There are two attending psychiatrists assigned to the hospital's two Behavioral Health Units 6 or 8. There is a total of four psychiatrists on duty at one time. Each psychiatrist usually carries an caseload of eight patients. These employees work Monday-Friday. The Residents hand-off their cases on Friday to whomever is working for the weekend. They also have on-call which starts at 5pm in the evening and carries over to 7 or 8am the next morning. When residents are on-call there is an attending physician for them to consult with.

There are several psychotropic and anti-depressant medications that the hospital has authority to administer under a court enforced medication order. Haldol is a commonly used antipsychotic that can have adverse side effects such as extrapyarmidal tremors, tongue protrusion, joint stiffness and pain. These side effects are not common and happen in rare instances. Haldol is routinely prescribed for symptoms such as agitation and aggression, which can be associated with mental health diagnosis such as bipolar disorder and schizophrenia. Drowsiness is the most commonly occurring side effect from a patient's use of Haldol. Other antipsychotics and mood stabilizers can also be used in combination with Haldol, but this is a decision made by the attending psychiatrist and the patient's care team. Benadryl is also ordered for treatment for some patients who are experiencing excessive salivation as an adverse side effect to Haldol. Cogentin is another medication that can be ordered if a patient is not able to tolerate Haldol. If a psychotropic medication triggers an emergency medical situation, then the unit would request the Rapid Response Team to respond to the medical emergency. Patients can report adverse side effects to anyone on the floor. The staff that typically

hear of patient's medication concerns first are nurses or certified nursing assistants who interact with the direct care of the patient. Once the nurse is made aware of a patient's concern, the chain of command expectation is for the nurse to provide this information to the physician and then follow the physician's recommendation for treatment. The psychiatrist is also able to consult with a medical hospitalist. The nurse is responsible for entering documentation in a progress note, chart flow sheets and complete nursing assessment.

A patient on the behavioral health floor does have the right to refuse medications. If a patient is refusing the team would discuss options such as adjusting current medications, adding a medication or discontinuing a medication. This decision would be made based on what the patient is reporting. The attending Psychiatrist must give orders for any medication changes.

The patient involved in this HRA complaint had been involuntarily committed on 9/10/2019 and had court ordered medications of Haldol, Zyprexa, Clozaril, Seroquel, Lithium, Depakote, Ativan, Cogentin, Artane, and Invega. Per a quick review of the medical chart during the site visit, as of 9/10/19, the patient was prescribed Clonazepam 1mg at night and 0.5mg of Klonopin on 9/15, 16, 17 and 18th. The patient also had Benadryl ordered due to excessive salivation but was not ordered for insomnia. This patient had also been on the behavioral health unit for 77 days. When a patient is involuntarily committed with court enforced medications, the psychiatrist consults with the patient's team which focuses on the clinical picture of the patient. When the team has created a plan of care and medications have been ordered the patient is given a list of their medications, a verbal discussion is facilitated, education sheets are provided, and the patient has the option to sign acknowledging consent to the medications.

A patient's care plan is created upon a voluntary or involuntary admission. If something with the patient's plan of care changes, then this information would be updated in the patient's chart right away. Information in the care plan is usually interventions put into place to treat behaviors and is not necessarily used for medication changes. If a patient is involuntarily committed this information would be included in the care plan and if medications are court enforced. Staff would be engaged with the patient during their whole admission process. Patients displaying symptoms of mania are difficult to engage in treatment sometimes due to the roller coaster of behavioral needs that are associated with this diagnosis. A patient admitted with court enforced medications does not have much input on what medications they will be prescribed. The physician can prescribe what they want without patient input to take, and the court enforced medication order is there for a reason. An attorney is also actively involved in the treatment of these patients. This patient was involuntarily admitted with court enforced medications and was awaiting transfer to a state operated mental health facility for further treatment and monitoring. The average length of stay on the behavioral health unit is 7-8 days and as previously mentioned this patient had been on the unit for 77 days. On 9/10/19 when this patient was admitted, there was concern of the patient being overmedicated based on symptoms of slurring words and being scared to leave the hospital. By that evening the patient was compliant with medications and even requested

medications. The next day the psychiatrist examined her. She had not been given any emergency or PRN medications to manage her behavioral health symptoms. When she was assessed by the attending psychiatrist, she was lying in bed and brought up her concerns of drowsiness. The side effects of her prescribed medications were reviewed with her and her Clozapine was lowered.

The record shows the patient requested a new physician on 8/2/19 and made her request in writing. Staff explained that it was just a request and the hospital does not have to change the attending doctor. In this case the Patient Advocate was contacted to follow-up with the patient's request. A patient can request a Patient Advocate at any time during their admission. This information is in the Patient Handbook, posted on the unit, and a phone is available all the time. If a patient is unhappy with a response to their written request that patient could file a grievance to request a change of doctor and this would go through the grievance process. The psychiatrist could tell the patient that they can request a new doctor and treatment team. Staff involved in the site visit were unsure if the patient filed a grievance. Staff stated that the due to the rotation schedule of Monday-Friday, weekends and on-call, the patient would have access to other providers during their admission.

A patient who has an order for court enforced medications still has their basic rights intact. They are provided with a copy of their involuntary admission, certificate, and court orders. They are also provided with an appeal form, restriction of rights form for medications when they are court ordered and for any restraints, other restrictions of rights or if they require suicide watch and must wear scrubs.

FINDINGS

#1- Inadequate staff response to patient's request for medication reduction due to side effects.

A UnityPoint Healthcare Methodist/Proctor Emergency Department Triage Note, written by a Registered Nurse (RN), dated 7/9/19, documents the patient reporting that she has not been taking any of her medications "…because I am feeling better." She was an involuntary admission to the behavioral health unit and admitted on 7/10/19. A Plan of Care Note written by an RN on the Behavioral Health Floor noted that her home medications at the time of admission were Risperdal 2mg, Bupropion 100mg, Benztropine 2mg, and Haldol decanoate 100mg that was last filled on 2/28/19. The patient requested and was provided with a copy of her patient rights on 7/13/19. She was notified of her court hearing for involuntary admission on 7/15/19. Notice of Patient Rights provided to patient on 7/9/19 upon admission to the behavioral health unit and the box is marked with an x that the patient refused to sign. The patient voluntarily signed on 7/15/19. The patient then requested a written 5-day discharge on 7/17/19 and cancelled the request on 7/23/19. The hospital filed for involuntary admission on 7/17/19 but patient continued to receive treatment on a voluntary basis.

A 7/25/19 Plan of Care note written by the unit Social Worker documents "Spoke

with [Outpatient Mental Health Counselor] from [Mental Health Provider], regarding pt's medication history. Per [Outpatient Mental Health Counselor], antipsychotic medication that pt has taken include Haldol and Risperdal. Pt seemed to do well on Haldol from [Outpatient Mental Health Counselor] perspective, but pt did not like the medication because it made her feel lethargic and thought Haldol was causing other side effects. However, those side effects continued even after Haldol was discontinued. Pt has also taken Risperdal but was most recently on a low dose because pt kept wanting the dosage decreased. A long acting injection would be a good option for pt because pt starts and stops medication on her own, but pt has not agreed to a long acting injection."

On 8/1/19 a petition for involuntary admission and court enforced medications is filed, given to patient by hospital Licensed Clinical Social Worker (LCSW), patient received a copy but refused to sign. Med list: Haldol (oral or intermuscular injection), Abilify (oral), Clozaril (oral), Lithium (oral), Trileptal (oral), Ativan (oral or intermuscular injection), Klonopin (oral), Cogentin (oral or intramuscular injection), Artane (oral), Vraylar (oral), and Ingrezza (oral). Several different blood work labs and an EKG were also on this petition. On 8/6/19 the court enforced medication hearing was continued until 8/13/19 due to patient taking meds. On 8/12/19 a Notice of Change of Status was filed by the hospital for court enforced medications filed/continued due to patient taking prescribed medications and signed for voluntary admission. The hospital received a court order for involuntary, transfer to a state operated facility for medication management with court enforced medications on 9/10/19.

On 9/5/19 a petition for involuntary admission, court enforced meds and transfer to a state operated facility was filed, given to patient by hospital LCSW, patient received a copy of the petitions and notice but refused to sign. Med list: Haldol (oral or intermuscular injection), Abilify (oral), Clozaril (oral), Lithium (oral), Trileptal (oral), Ativan (oral or intermuscular injection), Klonopin (oral), Cogentin (oral or intramuscular injection), Artane (oral), Vraylar (oral), and Ingrezza (oral). Several different blood work labs were ordered and an EKG.

The same Resident Psychiatrist treated her for all but two days during 9/1/19-9/24/19 when she discharged to a state operated facility. He reported to two different Attending Psychiatrists during this timeframe. Throughout the length of the patient's stay she was seen by five different Resident Psychiatrists. The HRA reviewed several University of Illinois College of Medicine Peoria (UICOMP) Psychiatry Residency Teaching Service Progress Notes and read the following:

> 8/2/19 "… Patient had a bad night where she was more agitated than usually. Stated to the staff that she needed to leave and "she had the jet waiting for her." Patient very upset and weeping thinking that her mother killed [Celebrity], stating, "she chopped him into pieces." Required a Haldol, Ativan, Cogentin PRN at 0300 to calm down. Took her morning Abilify. Medication compliance: noncompliance much of the time Medication side effects: denied for Abilify, tongue protrusion with the Haldol. …"

8/8/19 30 Day Review completed by the Attending Psychiatrist documents "[Patient] was admitted secondary to paranoia and delusional thoughts which was thought to be related to mania. Since admission she has shown improvement at times, but then decompensates. She has been tried on multiple medications and is currently being titrated up on Clozaril. She continues to have somatic, grandiose, and paranoid delusions. She writes about his delusions on the windows in peanut butter or toothpaste. In addition to lack of efficacy, medications may have been worsening her history of tardive dyskinesia; therefore, continued hospitalization is required to carefully monitor [Patient] for side effects of medications while finding an effective medication and dose of medications that will stabilize her psychosis."

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8/9/19 "… . When questioned about the frothing last night, the patient stated that she got dizzy last night when getting up and that she has been drooling a lot at night on one side. Denied ever having seizures before. Discussed with patient that these may be side effects from medications but will get EKG and orthostatic vitals to monitor. Patient still complains of fiberglass in mattress but putting more blankets on top seems to help prevent the discomfort. Seems to have more writings on the window in her bathroom that pertain to either celebrities or people Patient is still tangential in thought and delusional, but mood is improved. Denies any suicidal ideation. Also denies any auditory or visual hallucinations. When seen this afternoon, patient has been declining her CBC that was ordered. Discussed with patient that test is needed to see if we can figure out what is bothering her and for getting her medications. Patient stated she wanted another doctor.
Medication compliance: compliance most of the time Medication side effects: constipation, sialorrhea. …"

8/12/19 "… With no real improvement with patient's delusions, discussed the replacement of the Abilify with Prolixin. Patient brought up concerns of ever getting discharged if we keep changing the medications. Medication compliance: compliance most of the time Medication side effects: improved sialorrhea and constipation. …"

8/13/19 "… Since taking the fluphenazine last night, asked the patient if she noticed any uncontrollable tongue protrusion like she did when given the Haldol. Patient reported that she did not have any tongue protrusion but stated that she had some stiffness in her hip on the left. Patient stated that this stiffness is slowing her down. Patient stated that she had been doing dances in her room but denied any physical injury during this. Patient denied any stiffness elsewhere, like her arms. Patient denied any side effects from the clozapine or the fluphenazine. Patient has not taken her nightly dose of metformin the past 2 nights. When asked about it, the patient states she did not want to take it because it caused her to sweat more. Patient was still displaying delusions involving celebrities in both conversations with this provider and with nurses. Her attitude and emotions did not seem to be as labile as they had been in the past during this hospitalization. Medication compliance: compliance most of the time Medication side effects: Sweating from metformin, drooling and constipation from clozapine. …"

8/22/19 "… Medication compliance: compliance most of the time Medication side effects: Tardive dyskinesia with only fluphenazine. …"

8/23/19 "… Patient displayed slight psychomotor agitation this morning. Patient also displaying some tardive dyskinesia symptoms since not taking her clozapine last night. Patient was unwilling to answer why she was noncompliant with her medications last night. Proceeded to give patient her dose of clozapine this morning so no changes had to be made to it. Patient began to experience drooling in response and need to be given a diphenhydramine 50 mg dose. After getting the dose, patient was in her bedroom and somnolent. Tried to have a conversation with the patient, however, could not make out much of the words that she was saying. Patient could barely keep her eyes open. Patient's delusions appear to have gotten worse after missing a dose of clozapine. Unable to assess for auditory visual hallucinations. Unable to assess her depressive symptoms. Medication compliance: compliance most of the time Medication side effects: sialorrhea."

8/26/19 "… No tardive or akathetic movements seen during interview today. Patient looks to be tolerating medications well, but when asked about side effects patient worried that medications may be giving her 'dementia.' States that she is having trouble with her short-term memory, however patient is able to discuss what she ate for breakfast today and yesterday. She is also able to discuss events that occurred over the weekend. …"

8/27/19 "… Patient denied any side effects to the increased clozapine. There were some nursing notes that stated patient had excessive drooling even after being given Benadryl at night with the clozapine, however, there was none seen in patient's room. …"

8/28/19 "…Discussed with patient that since she did not like the side effects of

the medications at night, we could split the dose of her clozapine to being 100 mg in the morning and 150 mg at night. …"

8/29/29 "… Required PRN haloperidol 5 mg, benztropine 2 mg, and lorazepam 2 mg injection. …" There is a corresponding Notice of Rights Restriction noted in the patient chart dated 8/29/19. The narrative of this document indicates intermuscular injections were given but the box to note administered emergency medication is not checked."

8/30/19 "… Patient was observed in family meeting with her daughter. Patient did not allow this physician to sit in on the meeting. Was able to listen and from outside the room and heard patient discuss various topics with daughter. Towards the end of the meeting, the patient allowed this physician to participate in the meeting. Patient's daughter expressed concerns of patient being out of it to which I attributed to the medications that the patient is on. We split up the dose of her clozapine, so she gets morning coverage of it. She is also been off of the clozapine for almost a whole day, so some drowsiness is to be expected. Patient's daughter also expressed concerns of patient drooling during the meeting which this physician also observed. Told her that this is likely due to 1 of the medications that she is on. Due to the limited release of information, I was only able to discuss matters of the patient's hospitalization while the patient was in the room with her daughter. Was able to explain why patient has been here for so long with consistently taking medications, not responding well with some medications, and needing to adjust regimens. Discussed with both daughter and patient about plan of possibly getting patient on Ingrezza with a long-acting injectable of fluphenazine. Patient denied any auditory or visual hallucinations. Patient also denied any suicidal/homicidal ideations. Patient also does not seem to be responding to internal stimuli today. Discussed with pharmacy the process in order to get Ingrezza approved. We will follow-up on it. Medication compliance: compliance most of the time Medication side effects: Drooling."

8/31/19 ". Patient's delusions are still present, but her mood has become less irritable and labile since taking the clozapine. Replaced aripiprazole with fluphenazine due to patient being stable on typical antipsychotics in the past. Patient showing inconsistent compliance with clozapine dosing whether at night or during the day. Still displaying delusional content. Due to possible agitation/EPS symptoms will begin giving patient vitamin E 800 units daily for prophylaxis.…Patient was observed to be drooling a little bit during interview and informed the patient that the Benadryl that was supposed to be offered with her clozapine was put in system by this physician wrong. Corrected at this morning and she should be getting the Benadryl every time instead of an as needed. Patient expressed understanding. …"

9/2/19 "… Patient expressed concerns that she felt really tired this morning and was wondering if it had to do with her medications that she took. Discussed with patient that it is likely due to the increase since patient had only been taking 100

mg nightly and refusing to take the daily dose of her clozapine. Discussed with her that she likely will not feel tired is staying on the medication. Patient also expressed concerns of drooling last night however there was none seen with patient this morning and patient even agreed that it is improved since having the Benadryl scheduled with the nightly dose of the clozapine. Patient was able to carry on a conversation better about her past educational history and occupational history. Still tangential in the topics that were discussed. Patient brought up concerns at GlycoLax causes her muscles to relax and make her age faster. Discussed the mechanism by which this medication works and assured patient that it is not causing her to age. …"

9/5/19 "…Besides receiving her nighttime medications early yesterday, the patient did receive Haldol as needed injection for her agitation. She displayed no tardive dyskinesia movements during interview this morning like she has in the past and receiving PRN's. Patient also seem to be much more level headed in conversation since receiving the Haldol injections and she has not being on them. This makes the treatment team consider whether Haldol is actually the medication that stabilizes her the best. …"

9/6/19 "…Discussed with patient that we will switch her from Prolixin to a low dose Haldol to which she was resistant at first due to past experience, but explained that with the clozapine on board she is most likely not going to have any other movement side effects that she had in the past. Patient somewhat agreed to this plan. Medication compliance: Compliance some of the time. …"

Resident Psych #2 9/7/19 "… Tolerating Haldol well. No abnormal movements noted on assessment and no rigidity on exam. … Patient has been trialed on multiple medications during his hospital stay with intermittent compliance. Patient was compliant with nighttime medications. Patient appears about as well as what she was yesterday after receiving the Haldol injection 2 days ago. Because patient seems to be present much better after Haldol use, we are going to switch patient to low-dose of Haldol instead of the Prolixin. Patient expressed concerns of tardive dyskinesia that was present in the past while on Haldol, but explained to her that the clozapine she is on will decrease the chance of that. …"

Resident Psych #2 9/8/19 "… No acute events were reported overnight. Some drooling noted on assessment today. Very mild tremulousness present in hands bilaterally as well. No dystonia, rigidity, or dyskinesias noted. She reports doing well with current medications and denies auditory or visual hallucinations. No delusional content elicited. …" Second note completed by a different Resident Psychiatrist "… Patient has been trialed on multiple medications during his hospital stay with intermittent compliance. Patient was compliant with nighttime medications. Patient appears about as well as what she was yesterday after receiving the Haldol injection 2 days ago. Because patient seems to be present much better after Haldol use, we are going to switch patient to low-dose of Haldol instead of the Prolixin. Patient expressed concerns of tardive dyskinesia that was

present in the past while on Haldol, but explained to her that the clozapine she is on will decrease the chance of that. …"

9/9/19 "… Patient was lying in bed with covers over her. Patient complained of her medications making her more sleepy than usual. Discussed with patient that this might be due to her taking her medications at midnight compared to earlier in the evening when there is scheduled. Patient was resistive to any idea of scheduling her medications at night. Patient was less delusional than she has been. Has not heard from [Celebrity] or [Celebrity]. Denies any current drooling. Denied any restless leg or stiffening she complained of yesterday. No tremors or akathisia noted on examination this morning. Discussed with patient that she has court tomorrow. Patient expressed understanding. …"

9/10/19 "… Patient reports not having any side effects from the medication she has been given. …"

9/11/19 "… Patient brought up concerns of increased drowsiness and drooling with the medication regimen that she is on. We discussed that we can try to lower her clozapine dose to 150 mg in order to see if that decreases the side effect burden to which patient was agreeable. …"

9/13/19 " … Patient complains of drooling that happened but stated that it is better than what it has been in the past. Labs reviewed. …"

9/15/19 "… Still complains of some sedation, so we will look to decrease patient's Klonopin to see if patient has better. …"

9/16/19 "… Patient brought up concerns that the medications that she is on are too sedating and not allowing her to have more energy throughout the day. Reports that friends and family that she has talked to over the phone state that she sounds "over-medicated." Stated that we are going to decrease her Klonopin to see if there is a decrease in the patient's sedation. Patient expressed understanding of plan. Patient expressed feeling depressed (rating 5/10) about the transfer to [State Operated Facility] due to things that she has heard from others. Reported to patient that if she is stable enough before the transfer can occur, then we are not opposed to discharging her home. Patient acknowledged this. Discussed the possibility of using Haldol Deconate injection to help decrease that amount of pills the patient would have to take. Patient was not very receptive to this idea. … Because patient signed an ROI for her mother over the weekend, this provider had a phone conversation with her mother. Mother brought up concerns of patient being over-medicated when she last talked to her over the phone. Discussed that we are addressing this concern by decreasing some of her medications, like the Klonopin. Also addressed concerns about her history of tardive dyskinesia while on Haldol in the past. Discussed the use of clozapine to prevent the EPS [Extrapyramidal symptoms] side effects that had been witnessed. …"

9/17/19 "… Patient requesting to get off her Haldol and be placed on Risperdal. Patient discussed that she does not have any energy while she is on this Haldol medication like she had when she was on the Risperdal. Discussed with patient that this is because the Haldol is working and she is no longer manic like she was when she was on the Risperdal. Patient disagreed with this assessment. Patient still endorses slurred speech and slurring of words, however is speaking clear today and did not have any drooling noted during our conversation. Upon further questioning about patient's delusional thought content, patient became guarded and evasive during conversation. Patient asked about the family visit with her mother. Would not elaborate on whether it was a good or bad visit. Per social work note, mother seemed to be focused quite heavily on patient's appearance and slurred speech rather than the lack of delusional content that was spoken since being placed on the Haldol. Per nursing notes today, patient continues to be fixated on older delusions that she is had. Stated that she is afraid that her dog has been cremated and put into a box after a that dropped her up. Patient also brought up the concerns again about her daughter being abused. Patient has been intrusive during a long conversation of other peers on the unit. Patient called the at the saline requesting a new doctor. Patient denies any auditory or visual hallucinations."

9/19/19 "…Patient complained of night sweats last night though denies any residual fevers during the day. Patient has not had any fevers during vital recordings. Patient is concerned that she has malaria due to being chased by mosquito in the day room yesterday. Patient denied any history of traveling to tropical areas or travel to endemic areas before her hospitalization. Patient again complained about being on Haldol stating that she would prefer to be on Risperdal due to not being able to be as active as she was in the past. Reported that she was unable to keep up with people in exercise class when she used to be on Haldol but she was able to while on Risperdal. States that the Haldol caused her to have muscle stiffness. Explained to patient the issues with being put on Risperdal due to her presenting to the hospital and having delusions of a scabies infection while on the Risperdal. Currently does not have any muscle stiffness in upper and lower extremities while on Haldol. Denied any auditory or visual hallucinations …".

9/20/19 "On assessment today, patient was woken up from sleep. Patient's speech was clear and has been after discontinuing the nightly Klonopin despite just waking up. Patient reports that she still having issues with the Haldol. Reports that she had difficult times with participating in yoga yesterday. Stated that it was painful for her to sit with her legs crossed and she is noticing shaking in her arms related to past history of tardive dyskinesia. No tremor noted in upper and lower extremities. No tremor noted of patient's lips. No stiffness or rigidity noted on exam of patient's upper extremities. Discussed with patient that her exam looks normal and her lack of energy may be related to the Klonopin which was just discontinued last night. Patient disagreed with this and states that is probably from the Haldol and would like to be put back on Risperdal. Patient also reports

having fatigue present when trying to participate in your exercises on the unit and also when she tried to do her own Zumba routine. Denied having any shortness of breath or chest pain, just not having the energy to do it. Patient denied any worsening of the rash but she was complaining about, stating that the Benadryl cream helped with the rash. Patient reported a worsening of her depression rating it a 6/10 and stating that this is in response to her not having any energy or motivation to do things. Denies any change in appetite. Denies any problems with sleeping. She is able to concentrate on things during the day and able to watch her TV shows. Discussed with patient that due to her fatigue with exercise and movement, will get an EKG to make sure that her heart looks all right and will also get a CRP to make sure there is no inflammation. Denies any suicidal ideation. Denied any auditory or visual hallucinations."

The patient was intermittently cooperative with taking prescribed medications as ordered from 7/9/19-8/2/19. No medication complaints noted in the chart record reviewed by the HRA for the dates of: 8/10/19, 8/14/19 through 8/21/19. The Master Interdisciplinary Treatment Plan Record that is used by unit staff to notify a patient of the medications they are taking, and of side effects either verbally or in writing, is noted in the chart. It is clearly documented by staff that the patient would verbalize understanding of medications and their side effects but would refuse to sign the medication log. The HRA observed the patient refusing to sign the medication record 7/9/19-7/18/19, 7/22/19, 7/24/19-8/18/19, 8/20/19, 8/23/19-8/28/19, 8/30/19-8/31/19, 9/1/19 and 9/6/19. It appears based that after the court enforced medications was ordered on 9/10/19 the patient became cooperative and consistent with taking prescribed medications and began signing the medication log.

The HRA reviewed the UnityPoint Health Methodist/Proctor Behavioral Health Services Patient Handbook- Adult/Geriatric, revised on 2/2017, that is provided to a patient upon admission to the behavioral health unit. The handbook reads that "Often patients receive medication to reduce anxiety, alleviate symptoms, and induce rest. You will receive education about your medication. If you have questions or experience anything that concerns you, please inform your nurse or physician. For your safety and the safety of other patients, medications may not be kept in your room. … A session to understand medications is offered for you." Further on in the handbook, the patient is also informed, under the section titled Involvement in Care/informed Consent/Research/You/Your Representative's Rights Include, that the patient has the "3. Ability to make informed decisions regarding your care. This right includes being informed of your health status and diagnosis, prognosis (possible outcomes), proposed procedures (including risks involved), being involved in development/implementation/management of your plan of care and treatment, and being able to request and refuse treatment and to know what may happen if you don't have this treatment." The handbook also provides detailed information under the section titled Complaint/Grievance Procedure you/Your Representative's Rights. The section: "1. Ability to discuss any concerns/dissatisfaction with are received, which cannot be resolved by available staff, without being subject to coercion, discrimination, reprisal, unreasonable interruption of care, by contacting a Patient Advocate at [telephone

number] or ask any staff member to contact them on your behalf. 2. To be informed of the initiation, review, and when possible, resolution of patient complaints concerning safety, treatment, or services. Contact the Patient Advocate at [telephone number] or if you prefer, write your grievance and send to: Patient Advocate…." Lastly, the handbook also informs the patient under the section Patient Responsibilities: The Patient and/or When Appropriate, Family is Responsible For: "2. Inform appropriate healthcare professionals of any change in your condition or reaction to your treatment. … 4. Express any concerns you may have about your ability to follow and comply with the proposed plan of care or course of treatment. …"

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) Refusal of services; informing of risks states "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available."

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** (a) 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. … In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. … (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 …

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107.1) Administration of psychotropic medication and electroconvulsive therapy upon application to a court.** (a) (Blank). (a-5) Notwithstanding the provisions of Section 2-107 of this Code, psychotropic medication and electroconvulsive therapy may be administered to an adult recipient of services on an inpatient or outpatient basis without the informed consent of the recipient under the following standards: (1) Any person 18 years of age or older, including any guardian, may petition the circuit court for

an order authorizing the administration of psychotropic medication and electroconvulsive therapy to a recipient of services.

The **Mental Health and Developmental Disabilities Code 5/3-209. Treatment plan; review and updating** Within three days of admission under this Chapter, a treatment plan shall be prepared for each recipient of service and entered into his or her record. The plan shall include an assessment of the recipient's treatment needs, a description of the services recommended for treatment, the goals of each type of element of service, an anticipated timetable for the accomplishment of the goals, and a designation of the qualified professional responsible for the implementation of the plan. The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications. The plan shall be reviewed and updated as the clinical condition warrants, but not less than every 30 days.

COMPLAINT #1 CONCLUSION:

Inadequate staff response to patient's request for medication reduction due to side effects.

UNSUBSTANTIATED.

A patient was admitted to the behavioral health unit due to hallucination and unsafe behaviors that developed due to noncompliance with prescribed medications. She was admitted to the hospital for 78 days. The patient voiced concerns about her medication side effects, primarily a feeling of drowsiness most of her days of admission. The hospital clinical team treated her behavioral health needs while maintaining her patient rights throughout this time by continuously communicating with her about medications side effects and any prescribed changes to her medications. This is evident through the numerous Interdisciplinary Team Meetings documented in the patient record, a resident psychiatrist regularly communicating with her about prescribed medications and side effects making adjustments as necessary, also several other staff such as RNs and LCSW staff talking with her at each medication pass about reasons for the medication and potential medication side effects. This patient was intermittently cooperative with taking medications as prescribed until 9/10/20 when she was court ordered to take medications through the court. She frequently refused to take the medications up until then, which is within her rights through the **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107)**. Unfortunately, her mental health symptoms did not improve, and often worsened, when she refused to take the prescribed medications. The HRA did note from the site interview and chart review that she was prescribed 50mg of Benadryl to mask a side effect of the psychotropic medication Haldol and Clozaril. During her treatment, these medications were ordered to be taken at night due to the patient refusing to take the prescribed dosage during the day, due to feeling overly sedated during the day. This would explain the information in the allegation of feeling fearful to sleep at night. It should also be noted that this patient required fifteen-minute checks throughout her admission due to physical aggression, sexual aggression,

and elopement concerns and was checked by staff throughout her sleeping hours. The hospital petitioned the court in August 2019 for court ordered medications, but the patient had been compliant, so the hearing was continued. After this August court date, she again became intermittently compliant with medications. The hospital filed for court ordered medications and to transfer to a state operated facility for further medication adjustment. On 9/10/19, the state granted forced medications and transfer to a state mental health facility.

Because the hospital discussed treatment with the patient and due to the court ordered medication, there are no formal recommendations. The HRA would suggest the following:

- Each Notice of Rights Restriction form needs to be completed in its entirety and if an emergency medication was administered then the box should be marked to indicate this, as well as document it in the description section of this form.

- The HRA also reviewed a progress note on 8/30/19 the patient record reflects a progress note written by the attending physician that indicated the patient did not want the doctor in the room during a family meeting, so the attending stood outside of the room and listened. This should never happen and the HRA would encourage all staff to be reminded that a patient has the right to say who attends their family meetings.

- During the site visit interview staff indicated that the information in the care plan or treatment plan is usually interventions put into place to treat behaviors and is not necessarily used for medication changes. The HRA would suggest to ensure the facility follow the **Mental Health and Developmental Disabilities Code (405 ILCS 5/3-209)** pertaining to a patient's treatment plan "…The plan shall include a written assessment of whether or not the recipient is in need of psychotropic medications… ."

COMPLAINT #2:

2- Violation of patient's rights demonstrated by the hospital when staff refused to honor patient's request to be seen by a new psychiatrist.

A record review of the patient chart shows her first request to change attending physicians began in the ED the day of her admission on 7/9/19. The records reflect the patient requested a new ED physician stating preferably, "doctor of color". During the patient's inpatient treatment that began on admission 7/9/19 through discharge on 9/24/19 she was treated by the ED Physician, a Physician's Assistant in the ED, two non-psych medical doctors consulting, one who consulted on an EKG results during her inpatient admission and the other regarding her ingesting toxic medication prior to her arrival to the ED that is used to treat head lice, three attending psychiatrists, and five resident psychiatrists.

The record reflects two clearly written complaints about her attending psychiatrist documented in the patient chart. On 7/18/19 a Plan of Care Note written by a Registered Nurse at 1:43pm documents "patient reported she is unhappy with her doc and would like to switch to 'that new lady doctor'. Staff asked if there was anything specific that was upsetting her, and her response was 'Doctor doesn't do anything right…'" There is one handwritten note located in the chart that does not have a date associated with it. This note states in summary, that the patient does not want to work with the assigned psychiatrist and the letter is signed in a pseudonym she had used during her admission and not the patient's legal name. There is another form observed in the patient record dated 7/13/20, that is a UnityPoint Health Methodist/Proctor document with unknown title, that documents the patient requesting a new psychiatrist. Part of the patient's signature is observed on the form along with several other pseudonyms.

The HRA reviewed a Plan of Care note dated 8/2/19 and completed by a Registered Nurse which reads "Writer follow up with pt about reported request for another doctor. Unit informed pt called the Patient Advocate about getting another doctor. Writer asked pt this morning if she wanted to still request another doctor. Pt stated 'No I'm ok with him today'. Pt advised if [she] changes her mind to let staff know."

The hospital provided policy titled Process for Requesting a change of physician and/or 2nd opinion. The steps include: Patient/Guardian request a new physician or second opinion. Patient's current Attending Psychiatrist is notified by Nurse/Mental Health Clinician. Nurse assigned or Lead Nurse will then ensure the "Request for a new Attending Psychiatrist/Second opinion form" is explained, started and that this request can be documented in the Electronic Medical Record (EMR). Patient and staff sign, date/time form. The form is then placed in the patient's medical record. The current Attending Psychiatrist would consult other Attending Psychiatrist to review case and check for willingness for new psychiatrist to accept care of patient. If the new Attending Psychiatrist accepts care of the patient, that is noted on the 'Request for a new Psychiatrist form' and can be documented by the Psychiatrist in the new EMR. The Nurse or Mental Health Clinician can also provide documentation. The new Psychiatrist would assume care of the patient. If another Psychiatrist denies the patient's request for a new Psychiatrist or second opinion that is noted in the EMR. The "request for a new Attending Psychiatrist/second opinion from" is updated with the outcome. The patient/guardian is notified of this. The form is updated under the "outcome of request." The patient/guardian can rescind or cancel the request at any time. When the facility responded to the policy records requested for this case a newly created form was also provided that would be completed by staff when a patient made a request as mentioned above.

The HRA reviewed the UnityPoint Health Methodist/Proctor Behavioral Health Services Patient Handbook- Adult/Geriatric revised on 2/2017 and is provided to a patient upon admission to the behavioral health unit explains to the patient under the section titled Access to Care You/Your Representative's Rights Include number 6

informs the patient of the following “Receiving a consultation or second opinion from another physician as well as to change physicians.”

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) Care and services; psychotropic medication; religion** (a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.

The **Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) Refusal of services; informing of risks** (a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record. (c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record.
(d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition. …(g) Under no circumstances may long-acting psychotropic medications be administered under this Section. …

COMPLAINT #2:

2- **Violation of patient's rights demonstrated by the hospital when staff refused to honor patient's request to be seen by a new psychiatrist.**

UNSUBSTANTIATED

The HRA did not find any evidence in the patient record that UnityPoint Health Methodist/Proctor hospital violated a patient's rights by not honoring a patient's request to be seen by a new psychiatrist. The HRA observed the contrary in the patient record and documentation provides evidence that the patient had access to three Attending Psychiatrists and five Resident Psychiatrists during her 78-day admission. She made two complaints towards the same Attending Psychiatrist in July and September. UPHMP hospital staff responded adequately by having her put her request in writing, contacting the Patient Advocate, and having a verbal conversation about her request.

The HRA makes no formal recommendations.

The HRA would suggest the following:

- Ensure staff on the Behavioral Health Unit follow policy when a patient requests a new physician. There should be a documented note that two physicians discuss the patient's request and the outcome of this discussion is documented on the corresponding form.

- Update the patient's chart with The Mental Health Treatment Declaration which is a type of advanced directive for individuals with mental health needs. The Declaration allows individuals to pre-define their choices and preferences in mental health treatment. The HRA suggests educating unit staff on this option and providing patients with related resource information, including the Commission's link to the topic:
  https://www2.illinois.gov/sites/gac/Forms/Documents/DMHTForm.pdf

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, provider responses appear verbatim in retyped format.