FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 08-030-9009
JOHN J. MADDEN MENTAL HEALTH CENTER

The HRA substantiates the complaint that the facility administered psychotropic medication in violation of the Mental Health Code.

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 administered psychotropic medication in violation of the Code. If substantiated, this allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Madden Mental Health Center is a 269-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 Associate Medical Director, the Chief of Psychology, the Director of Nursing, the Assistant Director of Nursing and two Registered Nurses (RNs). Hospital policies were reviewed, and the recipient's clinical records were reviewed with written consent.

FINDINGS

According to the complaint, the recipient had made an appointment for 11:15 a.m. on 10/22/07 at the Intake Department of a local community mental health center to receive either medication or outpatient treatment for anxiety. He became very agitated during his intake process and the decision was made to have him involuntarily committed to a nearby hospital. Since this hospital had no available beds, he was then referred to Madden. He was transferred to Madden at 1:00 a.m. on 10/23/07, more than 13 hours after his initial appointment for help with his anxiety. The recipient stated that he was taken in an ambulance to Madden and remained in the ambulance for four hours until he was taken inside to the Intake Unit. He stated that he then remained in the Intake Unit during which time he was administered forced psychotropic medication. He was transferred to a Unit at 2:00 p.m. where he remained until he was discharged the following day at 7:00 p.m.

Madden staff were interviewed regarding this event. They stated that the recipient was brought to the facility on a petition and certificate from another facility and they were unsure how long the recipient had waited in the ambulance. They assured the HRA that since October of 2007 when this event took place, procedures have been put into place that would eliminate the waiting period in the ambulance, which is now less than 15 minutes. They also informed the HRA that they now have an Extended Evaluation Unit that is part of the Intake process, where recipients can be stabilized and observed for a period of time before being transferred to a Unit. They stated that since many recipients are not admitted who are evaluated in the Intake department, this eliminates unnecessary movement into and out of other Units and this is where the recipient in this case had been evaluated between the period of his arrival at 1:00 a.m. and 2:20 p.m. when he was taken to a Unit.

The Psychiatric Evaluation was completed on the recipient at 8:45 a.m. It states that the petition and certificate that were completed at the referring hospital reported that the recipient "stated that he might as well kill everyone if he doesn't get help immediately. He states that he has been carrying a knife and a club with him and has frequent conflicts with others. He is very paranoid and expresses extreme suspiciousness." This same document contains a section labeled Formulation that describes the risk evaluation for dangerous behaviors: "43 Year old male, white with history of mental illness treatment ……in 1985. Non compliant to medication threatened staff at the [referring hospital]. Reported as patient expressed thoughts of 'killing all'. As per sending report pt. was carrying a club and knife. During interview at Madden intake patient labile, loud, used 'F' words exhibiting paranoid and grandiose ideation. Labile. Used 'F' words during interview and walked out. Pt's affect: grandiose, labile. He is paranoid, pt. needs inpt. tx stabilization as protection for harm to others. Pt. admitted involuntarily on certificate."

The record indicates that the recipient was searched upon his arrival at Madden but had no weapons on him at that time.

The History section of the Psychiatric Evaluation contains the first reference to the recipient's behavior at the time of his forced medication: "Patient came to interview angry, labile, suddenly raised his voice stood up, reported (illegible)(cursing). Pt. left interview session escorted by staff. Pt. was given Olanzapine 10mg IM stat and Lorazepam 2mg IM stat with Restriction of Rights. Pt. grandiose, paranoid, labile, exhibits poor impulse control, poor judgement. Needs inpt. treatment and protection for harm to others." The Medication Administration Record indicates that the recipient was administered 10 mg Olanzapine IM and 2mg Lorazepam IM at 9:20 a.m. and the accompanying Physician's Order, written at 9:00 a.m. states, "Pt. labile, threatening behavior, considered danger to staff."

The nurse who had been on duty at the time of this incident was present at the site visit and was asked about this incident. She stated that the recipient was being evaluated by the doctor and the doctor came out of the examining room and stated that the recipient had attempted to hit him. The Nursing Notes that were entered into the Progress Notes for 10:15 a.m. state, "Pt. was given Olanzapine 10mg IM stat and Ativan 2mg IM stat for threatening staff and labile mood. Patient was cursing at MD and refusing to respond to verbal directions. Patient is aggressive, threatening, and considered a danger to self and others at this time."

There is a Restriction of Rights Notice for this event. It states, "Pt. threatened community staff to kill him and became extremely labile, while with the psychiatrist, refused to respond to verbal direction, cursing and swearing. Pts behavior is a danger to self and others."

The recipient was discharged the following day at 7:00 p.m.

STATUTORY RIGHTS

The Mental Health Code guards all adult recipients against the use of unwanted services, including medications, unless it becomes necessary to prevent serious and imminent physical harm:

> *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. (405 ILCS 5/2-107a).*

Whenever a guaranteed right within Chapter II of the Code is restricted, the facility must issue a notice that describes the reasons for the restriction to the recipient and any person or agency he or she designates (405 ILCS 5/2-201).

HOSPITAL POLICY

Madden Mental Health Center policy (#230 Refusal of Services/Psychotropic Medication) states that adult patients are to be given the opportunity to refuse generally accepted mental health services, including but not limited to medication. If such services are refused, the policy states that they are not to be given unless such services are necessary to prevent the patient from causing serious and imminent physical harm to self or others. A physician's order for the medication must accompany an order for emergency medication. Also, the nurse shall document the circumstances leading up to the need for emergency treatment in the patient's record along with the rationale. Policy also dictates the completion of the Notice of Restricted Rights of Individuals.

CONCLUSION

The recipient in this case made an appointment at 11:15 a.m. on 10/22/07 at a community mental heath facility to receive medication or outpatient counseling for his anxiety. It is reasonable to expect that after being held for more than 20 hours he would be uncooperative, angry and paranoid during his evaluation for his involuntary commitment at Madden Mental

Health Center. However, it is difficult, if not impossible to tell from the record what behaviors the recipient exhibited that then warranted his administration of forced psychotropic medication. The Psychiatric Evaluation states that the recipient had mentioned in his interview at the referring facility that he "might as well kill everyone if he doesn't get help immediately." There is no indication that he made any threat of this kind in his evaluation at Madden. Also, the referring facility had mentioned that he stated he had been carrying a knife and a club, but the facility did not say that he had a weapon on his person when they interviewed him, and he did not come to Madden with a weapon, as this is documented in his record. The Evaluation completed at Madden states that the recipient threatened staff at the referring facility but it is not documented in the record that he threatened serious and imminent physical harm to the staff at Madden. Our only documentation of the physical threat of harm is the verbal account given by the nurse on duty at the time who stated that the doctor had said that the recipient had attempted to hit him. This account did not appear in the written record, not even in the Nursing Notes.

The Madden record of the recipient's evaluation describes him as "paranoid", "suspicious", "non compliant with medication", "labile", "loud", "grandiose", and "cursing". It also indicates in two places that the recipient left the interview session. The Medication Administration Record describes the recipient as "labile, threatening behavior, considered danger to staff." Again, in the Nursing Notes, it states that the recipient was given forced medication because he was "….threatening staff, labile mood. Patient was cursing at MD and refusing to respond to verbal directions." The Notice of Restricted Rights of Individuals is also confusing. It states that the recipient "threatened community staff to kill him and became extremely labile while with the psychiatrist, refused to respond to verbal direction, cursing and swearing. His behavior is a danger to self and others." This suggests that the recipient had threatened the staff at the referring facility and not at Madden. Nowhere in the written record is there a description of specific behaviors that indicate how the recipient was threatening or a level of dangerousness toward himself or others that would warrant emergency treatment. The nurse's description of dangerousness certainly rises to the level of "imminent threat of physical harm", however she did not witness this action and it was not documented in the record.

The HRA substantiates the complaint that the facility administered psychotropic medication in violation of the Mental Health and Developmental Disabilities Code and Madden Mental Health Center policy.

RECOMMENDATIONS

1. Instruct staff to follow the Mental Health Code and program policy requirements and administer emergency medications only to prevent serious and imminent physical harm (405 ILCS 5/2-107).
2. Be certain that Restriction of Rights Notices and corresponding progress notes are completed thoroughly and comply with Mental Health Code and hospital policy. Descriptions of behaviors must be specific and indicate the threat of serious and imminent physical harm. (405 ILCS 5/2-107 and 5/2-201).

RESPONSE

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

Rod Blagojevich, *Governor* Carol L. Adams, *Secretary*

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8/15/2008

Katherine Dunford, Chairperson
Human Rights Authority
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Re: #08-030-9009

Dear Ms Dunford:

We have reviewed your response to Madden's concerns regarding the above complaint. We are pleased that you are willing to work with us in a collaborative way to ensure that patient rights are not restricted in the absence of due process and that you recognize the importance of staff and patient safety. As before, we contend that the information presented in the chart indicates that the patient did pose a serious and imminent risk necessitating the use of authorized involuntary treatment. Our contention is corroborated by the nurses statement referenced in your letter.

However your comments regarding proper documentation have merit. We believe that accurate and thorough documentation is an essential element in providing good patient care. Additionally such documentation can prevent misunderstandings in regards to cases such as this and can be pivotal when concerns arise about potential problems with quality of care.

In the light of these issues, we have discussed the need for thorough documentation with the persons involved in this case. I have furthermore distributed excerpts from your letter detailing your concerns to the medical staff and asked that they review them so that they will be able to more carefully document the rationale behind any future restrictions of rights.

Your comments on the progress made at MMHC in regards to human rights are appreciated. Although we may not always agree on particulars, our administrative staff looks forward to a continued collaborative relationship with the Human Rights Commission. I am not sure that it is necessary for us to attend your next meeting, we will be glad to do so it you feel that it would be valuable. Also do not hesitate to contact me at 708 338 7280 if I can ever be of assistance to you.

Sincerely

R. Sharpe

Robert C Sharpe MD FAPA
Associate Medical Director