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North Suburban Human Rights Authority
Report of Findings
Elgin Mental Health Center
HRA #09-100-9034

Case Summary: the HRA substantiated the allegation that emergency medication was given without justification; the remaining allegations were unsubstantiated. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Elgin Mental Health Center (EMHC), Forensic Treatment Program, Unit G. In May 2009, the HRA notified EMHC of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation are as follows:

- A consumer was denied a shower
- A consumer was not allowed to shave his head
- A consumer was only given Tylenol for his migraines which did not alleviate the pain
- A nurse breached confidentially by talking about a consumer's medical problems in the dayroom
- A consumer complained of chest pains and trouble breathing and he was not given a medical examination
- A consumer was given enforced medication without justification
- The physician used medication as a threat/punishment
- A consumer's room was dirty

The rights of consumers receiving services at EMHC are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 5/2-107, 5/2-112 and 5/2-104) and the Mental Health and Confidentiality Act (740 ILCS 110).

To pursue this investigation the HRA reviewed, with written authority, a portion of the clinical record (April 2009) of the consumer whose rights were alleged to have been violated. An on-site visit was conducted in June 2009, at which time the allegations were discussed with the consumer's Case Worker and the consumer's attending Physicians. The consumer was also interviewed via telephone.

Background

Consumers receiving services at EMHC's Forensic Treatment Program have been remanded by Illinois County Courts to the Illinois Department of Human Services (DHS) under statutes finding them Unfit to Stand Trial (UST) and Not Guilty by Reason of Insanity (NGRI). Placement evaluations determine the most appropriate inpatient or outpatient setting for forensic treatment based on a number of factors including age, gender, mental health diagnosis, and security need.

Unless a person is specifically ordered to receive services in an outpatient setting, court ordered referrals under state forensic statutes call for placement in a secure inpatient setting. The Forensic Treatment Program has 315 beds.

Allegation: A consumer was denied a shower

Findings

The clinical record revealed data on a male consumer admitted to the Center on April 8, 2009 at about 9:00 a.m. He was found UST on a felony charge of Driving Under the Influence of Alcohol. The Comprehensive Psychiatric Evaluation noted that he has had 27 prior DHS admissions, numerous prior private psychiatric hospitalizations and history of prior arrest.

On the first night of admission at about 10 p.m., progress notes documented that the consumer was argumentative when he requested to take a shower and was told about the unit shower times. The note states that he was counseled and the unit rules were explained, to no avail. According to documentation, the consumer went from staff to staff asking why he could not take a shower and he claimed that he was not told the unit rules. The consumer was reminded that shower times had been announced several times. The consumer wanted to file a complaint with the Illinois Office of the Inspector General (OIG) about being denied a shower; the call was made. It is noted that the consumer had difficulty reaching the OIG (midnight); he then advised a staff member that he would report her for denying/refusing him to use the telephone because he unsuccessfully connected to the OIG. The HRA contacted OIG to see if this compliant had been filed; the OIG advised the HRA that they had about twenty complaints made by this consumer, but nothing about a denied shower. The Initial Psychiatric Nursing assessment documented that the unit rules were explained.

At the site visit, the HRA learned that consumers are, in fact, encouraged to take a shower upon admission. Each shower time is announced over the unit intercom and explained during the unit rule orientation. The showers are scheduled to maintain safety on unit. There are currently 25 consumers on the unit; the unit has three showers. The posted shower hours are:
5:30AM – 6:00AM
7:30AM – 8:30 AM
11:30AM - 1:30PM
5:30PM – 6:30PM.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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 consumer had the opportunity to take a shower during the scheduled shower times. The allegation that he was denied a shower is unsubstantiated.

Allegation: A consumer was not allowed to shave his head

Findings

The only reference about this allegation in the chart was that it was noted on the Psychiatric Evaluation that he was admitted with a shaven head and that he had a beard. The consumer told the HRA that the barber had shaved his head, but he wanted to shave it himself.

At the site visit, Center personnel stated that once a consumer has been assessed as able to use a safety razor to shave safely, the razor can be used for the face or head, provided that there were no medical contraindications – dermatitis etc. It was stated that the barber is typically used for the initial head shave to remove excess hair.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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 consumer's head was shaven by a barber; there was nothing in the chart to indicate that he was allowed or not allowed to use a razor. The allegation is unsubstantiated.

Allegation: A consumer was only given Tylenol for his migraines which did not alleviate the pain

Findings

The record showed that the consumer was given several different medications for his complaints of migraine headaches (Tramadol, Topiramate Tylenol, Vicodin). The trail of Tramadol was stopped because of possible interactions with his other medications and because it was ineffective. The record showed he had good relief from the Vicodin.

There was concern expressed in the record that his migraine headaches did not appear typical, in that he would be observed interacting normally with other patients and in no apparent distress just before, and after, asking for pain relief. The record also indicated that drug seeking behavior was considered a possibility.

The physicians interviewed reiterated the chart, in that different medications were used to relieve his complaints of migraine pain. And, they also reiterated that the consumer might have been drug seeking.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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 allegation is unsubstantiated; the chart showed that the consumer was given medications other than Tylenol for his migraines.

Allegation: A nurse breached confidentially by talking about a consumer's medical problems in the dayroom

Findings

The consumer reported to the HRA that his confidentiality was breached when his medications were dispensed through the medication window, in that people in the day room could hear what was being said.

On April 11th, nursing notes documented that the consumer "demanded" a PRN (as needed) medication. When he was asked why he needed the medication, he replied that he was upset because he did not have a dresser in his room. (The dresser had been just been removed for safety reasons as the consumer had placed the dresser on top of his bed; then he dismantled a shelf and began to move it around the room). The note indicated that the consumer was encouraged to used relaxation techniques before asking for medication. The consumer became irritable and accused the staff of breaking the HIPAA law (The Health Insurance Portability and Accountability Act) by discussing his medication in front of his peers. It was documented that the staff and the consumer were in the medroom window when the consumer was asked why he needed the PRN medication. It was noted that other consumers were in the dayroom watching TV and that no one was paying attention to the conversation.

The HRA toured the unit and examined the drug-dispensing window. It is solid glass with a small pass through on the bottom, which can be opened from the inside when the nurse, from behind the glass, passes the medications. The HRA found that it would be difficult for anyone in the day room to see or hear the nature of medication transactions.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act (Act). Section 3," All records and communications shall be confidential and shall not be disclosed except as provided in this Act." Disclosure is made upon authorization from the recipient under Sections 4 and 5. Based on the information obtained, the allegation is unsubstantiated.

Allegation: A consumer complained of chest pains and trouble breathing and he was not given a medical examination

Findings

According to MOD (Medical Director on Duty) notes, on April11th, the consumer had complained all day of sharp pain that went to his left arm and head causing a migraine. The consumer wanted to go to the Emergency Department (ED) at a nearby local medical hospital. The consumer was assessed, and he was noted to not appear to be in any discomfort; medications (Lorazepam, Hydroxide) were given and he was to follow-up with his primary care physician. The following day it was documented that the consumer complained of a migraine and chest pain. The physician was contacted and he assessed the consumer; medications (Tylenol, Maalox and Ativan) were given. It was documented that the consumer "made threats that he'll do everything in order to go the ED." On the 13th, the consumer's PCP (Primary Care Physician) referred him to the Cardiology Clinic. On the 19th, he complained of chest pain radiating to his shoulder; he was assessed and observed. It was noted that after the initial complaint of the pain, he made no further complaints. The Cardiology appointment was scheduled for the 20th; this appointment was cancelled.

The physician reiterated what was in the chart, in that when he made complaints of chest pains, and a MD examined him. The pain was assessed as atypical and possibly due to an anxiety attack. The consumer was referred to Cardiology and the HRA was told that the cancelled appointment was rescheduled and the Electrocardiography examination was normal and that further work up was to be done on an out patient basis as he had been discharged from the facility.

The Center's Plan for Patient Services policy states that EKG examination services are ordered by the examining physician and are provided at the Center.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, Section 5/2-112, every recipient of mental health services shall be free from abuse and neglect. Based on the information obtained, the allegation is unsubstantiated in that the consumer's complaints of medical symptoms were assessed by a physician.

Allegations: A consumer was given enforced medication without justification
The physician used medication as a threat/punishment

Findings

On April 12th, documentation indicated that after an hour of reading the Bible with other peers, the consumer approached nursing personnel and demanded to be seen by his physician for a migraine headache. It was noted that the consumer was counseled. The nurse spoke to the Physician who relayed that he/she would not send the consumer to the ED for a migraine and the

consumer was encouraged to take Tylenol. The consumer refused the Tylenol, told staff that he knew what to do to get to the ED and walked toward his room. Notes documented that he was asked to return to staff, but he began escalating, he was loud and swearing. He was then offered a PRN but when he learned what it was (Geodon) he refused stating that he would have side effects. He was told that if he had side effects, medications would be given to stop the side effects. He refused the Geodon and demanded Vicodin. The MOD was called and orders were given to restrict the consumer's right to refuse the medication. The medication was given intramuscularly and it was noted that he was not cooperative. The record did not indicate what less restrictive alternatives were considered before the emergency medication was given.

On the 17th, it was documented that the consumer was argumentative, needy and demanding to go to the hospital for facial psoriasis. Cream was offered which was refused. It was documented that the consumer was very restless and upset. A few hours later his face was noted to be slightly bleeding; he reported that he scratched it because it was itching and demanded to go to the ED. It was documented that he became agitated and disruptive to the milieu. He refused medication to help him calm down and his rights were restricted. It was documented that medication was administered to help him calm down and due to self-injurious behavior. The completed Restriction of Rights Notices mirrored the progress note documentation (escalation, self injurious behavior) regarding the need for the restriction and the Notices indicated that his emergency intervention preference was used and that he wished no one notified. The record did not indicate what less restrictive alternatives were considered before the emergency medication was given.

In discussing this allegation, the Physician stated that emergency medication is used when the consumer is unable to calm down on his own and when there is a threat of harm. It was also explained that medications were not used as punishment, but when they began to taper his Vicodin because of concerns about possible drug seeking and addictive issues, he became very upset.

The Center relies on the Illinois Department of Human Services policy and procedure directives regarding the administrative of psychotropic medication. The Directive (02.06.02.020) states that "An individual's refusal to take psychotropic medication does not in itself constitute an emergency. An individual's refusal to take psychotropic medication, as documented in the clinical record shall be honored except in the following circumstances. In an emergency, when treatment is necessary to prevent an individual from causing serious and imminent physical harm to self or others."

Conclusion

Pursuant to the Mental Health Code, Section 2-107, "An adult patient of services or the patient's guardian, if the patient is under guardianship, and the patient's substitute decision maker, if any, must be informed of the patient's right to refuse medication. The patient and the patient'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. If such services are refused, they shall not be given unless such services are necessary to prevent the patient from causing serious and imminent physical harm to the patient or others and no less restrictive alternative is available."

Although the medical/nursing team might have seen a need for the administration of emergency medication on the 12th, the words agitated, loud and swearing do not translate to the need to prevent serious and imminent physical harm to the patient or others. Consumer rights were violated.

Recommendation:

- Hospital personnel must ensure that documentation supports the need for emergency medication as mandated by Section 5/2-107 of the Mental Health Code, in that the patient

must be given the opportunity to refuse the medication, and if refused, only given to prevent serious and imminent physical harm to the patient and/or others when no less restrictive alternative is available.

Allegation: A consumer's room was dirty

Findings

At the site visit, it was stated that the consumers are expected to keep their own room clean; they are to make their beds, keep their clothes off the floor, and dust and sweep. Cleaning chemicals are not given to the consumers. There was nothing in the chart to show that the consumer's room needed cleaning.

Conclusion

Pursuant to Section 5/2-102 of the Mental Health and Developmental Disabilities Code, "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 HRA does not dispute the claim that the room was dirty, however no evidence was found to support the assertion. The allegation is unsubstantiated.

RESPONSE

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

Pat Quinn, *Governor*

Carol L. Adams, Ph.D., *Secretary*

Illinois Department of Human Services

Division of Mental Health - Region 2
Elgin Mental Health Center ▪ Singer Mental Health Center

RECOVERY IS OUR VISION
Recovery is a Personal Journey of Hope, Healing, Growth, Choice, and Change

August 17, 2009

Mr. Dan Haligas - Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Street, W-300
Des Plaines, IL 60016-1565

Re: HRA #09-100-9034

Dear Mr. Haligas:

Thank you for your recent thorough investigation of this case. We have reviewed your HRA substantial case finding of inadequate documentation concerning administration of emergency medication.

We agree with your finding of inadequate documentation of the incident in question. I note that the Progress Notes clearly, and in considerable detail, documented staff's conscientious and consistent efforts to treat the patient with a variety of less restrictive interventions, which efforts were not fully conveyed in the Restriction of Rights.

Based on your finding, our Medical Director will review with the physicians in question the correct manner of documentation of criteria for emergency medication, and put the matter on the agenda for further discussion at the next meeting of the hospital's Medical Staff Organization. Nursing administration has re-educated all FTP Nurses and Nurse Managers in the proper compliance of the Restriction of Rights form and Progress Notes. We will be monitoring compliance over the next several months.

I would request that this response be attached to the report and be included with any public release of your Report of Findings.

Sincerely,

Tajudeen Ibrahim, BA
Acting Hospital Administrator

TI/JP/DH/aw

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