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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9005
H. DOUGLAS SINGER MENTAL HEALTH CENTER

Case Summary: the HRA substantiated violations of using emergency meds on a patient when there were no reasons to; the facility's response follows.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the treatment of a recipient at H. Douglas Singer Mental Health Center, a state-run hospital in Rockford that has over seventy beds.

It was alleged that the facility did not follow requirements for administering emergency medications. Substantiated findings would violate rights protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5) and Illinois Department of Human Services policies.

The HRA met with the facility's quality manager and nursing manager to discuss the matter. Program policies related to the complaint were reviewed as were sections of the adult recipient's record with her authorization.

COMPLAINT STATEMENT

According to the complaint, a recipient was given forced medications without adequate reason. She reportedly got into a verbal exchange with staff about being on the dayroom couch when she was called to her room where several staff and guards lowered her pants and gave her an injection. She was allegedly still getting emergency administrations after a couple of days, without a need to prevent harm and without less restrictive alternatives. It was also said that the recipient was not provided with rights restriction notices every time and was not asked if she wanted anyone notified.

FINDINGS

The recipient's medical record showed that she was admitted to Singer involuntarily on October 5th, 2009. Admission forms and assessments noted that she refused medications, had no

preference for emergency intervention and that she designated someone to be notified should her rights be restricted, but she only provided a first name and incomplete contact information.

Progress notes from the first night of admission described how the recipient stayed awake all night, displaying agitation, religious delusions and inappropriate touching, which, according to the entry, put her in potential harm from other patients. A psychiatrist wrote around 10:00 a.m. that she was highly manic and delusional yet refused medication that could help her. She made no physical threats, but was touching peers inappropriately; he ordered Olanzapine by injection immediately and by mouth two more times that day with options to inject if refused. His initial emergency medication determination form noted that the recipient was pacing constantly, screaming, agitating others and causing a peer to chase her. He wrote that she would not cooperate with verbal approaches and that she was in imminent danger of being harmed by others. Nursing entries around the same time stated nearly the same: the recipient was provoking peers and one had chased her. The difference in documented reasoning was that per the nurses, she was screaming only after the fact when she struggled with staff against the injection. She was given a first injection at 11:30 a.m. according to the medication administration record, and there is no evidence anywhere in the chart that she was educated about the drug she was made to take. A nurse wrote that a restriction of rights form was completed and given to her. The corresponding form listed mania, pressured speech, calling 911, delusions of pregnancy, telling another recipient the baby was his causing him to run after her, at risk of harm, being resistant and combative with staff and danger to self and others as reasons to restrict her right to refuse medication. No preference was acknowledged, but the designated contact person included a last name and indication he was notified, contrary to earlier documentation. Progress notes through the rest of the day until 10:30 p.m. described her as calmer, without a single potential incident or need to prevent serious and imminent physical harm noted. Still, a second emergency dose was given without documented indication that less restrictive alternatives were considered to prevent the emergency. Nursing entries referenced another restriction notice, which stated that the recipient took the emergency dose for pacing, screaming, agitating others, causing a peer to chase her and because she would not cooperate with verbal approaches, simply repeating the documentation from earlier that morning although not one of those behaviors was repeated per the record. A nurse wrote at 6:30 the next morning that the recipient slept on and off and continued to agitate peers "…causing threats to her person. Otherwise, patient is cooperative and pleasant." Emergency medication was given along with a restriction notice. That notice cited mania and touching others into provoking harm as reasons to force the treatment; it indicated that no one was designated to be notified, contradicting the first two forms.

A redetermination form was completed at 6:30 on October 6th as well. It stated that emergency medications were needed because of mania, pacing and inappropriately touching others, agitating them to causing threats to her own well being and not following directions well, conflicting with being otherwise cooperative and pleasant noted at the same time. New emergency orders were written at 9:00 a.m. for Olanzapine three times per day. According to nursing notes at 11:00 a.m., the recipient took another emergency dose by mouth protesting, "I don't need these fucking meds." The nurse explained they were emergency ordered and that she would get them by injection if she refused. A restriction notice was completed and given to her, and the nurse noted that the recipient's behavior was intrusive and hostile. The corresponding restriction notice stated that emergency medications were given because the recipient's behavior

was leading peers to verbally threaten her and that a peer "choked her as a result of her behavior." There is no documented incident of being choked while at Singer, except that a social worker noted in the record just an hour earlier that the recipient's ex-boyfriend choked her a month ago. The restriction notice listed the full name of her designated contact, but explained that his address was not provided. There were no more entries in the record until the next emergency at 9:00 p.m. A nurse wrote that she consulted with an on-call physician who agreed with an emergency administration, the reasons for which were not included. The only detail provided was a direction to the recipient that if she did not take the dose by mouth she would get an injection; the recipient complied and there was no reference as to whether less restrictive alternatives were considered to prevent serious and imminent physical harm. The accompanying restriction form stated that pacing, mania, touching others, sexual inappropriateness, and irritating others to threats of harm to her own well being were reasons for the need to prevent the emergency, citing incidents from the day earlier although not one instance of similar behavior was noted since.

An emergency redetermination form completed at 6:00 a.m. on October 7th stated that when not on medications and with a history of mania there were threats to the recipient's person. Regarding less restrictive alternatives, it said that she did not follow direction well when not on medications but that her behavior "is calm and cooperative this morning"; nursing notes for the emergency administration agreed by stating that she was quiet and cooperative. She was given the emergency dose, and the 6:00 a.m. restriction notice that followed listed inciting others to aggressiveness as the reason. A new emergency order was written at 9:50 a.m. for Olanzapine, three times per day. The psychiatrist's note stated that the recipient remained quite manic and a danger to herself and others "by virtue of her excessive inappropriate argumentativeness which recently led another patient to become provoked and chase her down the hall." He added at 11:00 a.m. that emergency medications were still needed because she had cigarettes smuggled onto the unit and that they ended up in the hands of a peer who previously tried to set fire to himself. He went on to propose that her displayed poor judgment and inability to reason for her manic condition would put herself and others in danger. Nursing notes reflected the emergency dose given at 11:00 a.m. stating that the recipient did not want to take it. Again, there was no mention of less restrictive alternatives at all. The restriction form listed seclusion as a designated preference but that she was not in need of such restrictive measures to control dangerous behavior. It also stated that a copy was given to the Guardianship and Advocacy Commission by office mail.

This writer was visiting with the recipient at 11:00 a.m. when the emergency medication was given. We had been meeting for an hour during which time her behavior was entirely appropriate. She could not understand why she was still being force-treated and could not remember being asked if she had an emergency intervention preference and wanted to designate seclusion and the Guardianship and Advocacy Commission to be notified. She had a folder of all papers given to her since admission, which included only two restriction forms that were completely illegible. Although by this time she was given six emergency doses, she said she was given only these two notices. We walked to the nurses' station to provide the designation changes as a nurse immediately handed her a pill. The recipient said she did not want it, and the nurse told her it was an emergency and that she would get a shot if refused. Not one hint of the need to prevent serious and imminent physical harm was displayed and there was no

consideration or attempt to contain the emergency with less restrictive alternatives before she was made to take it. This writer followed up with Singer's quality manager soon after and requested a copy of the restriction notice to see why the medication was given and waited for one to be completed. The copy provided was illegible and another one was requested and received by inter-office mail eight days later.

The record stated that emergency medications were discontinued after the 11:00 a.m. dose on the 7th and that seclusion could be used if there was any further need.

Singer's nursing manager explained during our interviews that there is no formal training on emergency medication use but that the quality manager reviews all records and provides feedback to nursing when needed. She said that the Department of Human Services made some changes in the last year that requires nurses to assess emergency situations and contact physicians before giving emergency doses. Physicians can no longer write three-times-per-day orders. Medication education is always provided and charted. Regarding the opportunity to refuse, she said that if there is a written order it must be followed. Nurses and physicians should review potential alternatives and designated preferences together.

The quality manager also said there was a new state-wide directive from the medical director that all emergency medications require calls to physicians before each administration, even at 6:00 a.m. He has not seen this directive in writing, however. Although there is no formal training module on the emergency medication process, he reviews emergency instances from the record documentation and provides feedback to the nurses for continuing education. He did not say that physicians were included. The charting should reflect medicine education but was not evident in this case. He said that every attempt should be made to reach designated persons to receive notice of rights restrictions but that this recipient would not provide enough contact information or sign a release for the hospital to follow through. He agreed that eight days for the Guardianship and Advocacy Commission to be notified is not prompt.

CONCLUSION

Singer policy (Rights of Individuals: Notification of Rights and Restriction of Rights, revised 3/12/08) states that notices will be completed whenever a patient's rights are restricted. Notification is given to any person or agency so designated, but the policy does not require it to be done promptly. Less restrictive measures are implemented when possible, attempts at which are documented in the record. Singer's medications policy (PPD 02.06.01.02, revised 6/30/97) defines an emergency as "an impending or crisis situation which creates circumstances demanding immediate action for preservation of life or prevention of serious and imminent bodily harm…." A patient's refusal to take medications in itself is not an emergency. It shall be documented in the record why less intrusive means are not appropriate. A physician's order must be written in the record with each administration of medication, and the prescriber will make emergency determinations based on examination every twenty-four hours. Redeterminations can be made by nurses in consultation with physicians. Emergency medications cannot exceed seventy-two hours, excluding weekends and holidays, without documented continuing need and a petition to force treatment is court filed. The facility's medical director or designee must approve in writing any continuance beyond the same seventy-two hour rule. A restriction notice is completed for each administration.

Under the Mental Health Code,

> 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…. (405 ILCS 5/2-102 a).
> An adult recipient of services…must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient…shall be given the opportunity to refuse generally accepted mental health…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*.
>
> 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.
>
> 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.
>
> 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.* (405 ILCS 5/2-107 a, b, c and d; emphases added).

Section 5/2-200 provides recipients the right to designate any person or agency to be notified of restrictions and to select a preference for emergency intervention, which must be considered for use. Section 5/2-201 adds that completed restriction notices must be given promptly to anyone so designated.

Here the need to start emergency medications is questionable at best. The prescribing psychiatrist said that the recipient was highly manic and delusional yet refused medication that could help her. She made no physical threats, but was touching peers inappropriately. Nurses documented further that she had provoked one peer into chasing her. Medications were ordered first by injection and again by mouth two more times that day with options to inject if refused. More certain are the violations of the recipient's due process rights that followed. The record provided no evidence that she was ever educated about the Olanzapine she was made to take. All continuing administrations claimed the same behaviors from the initial determination although they never occurred again and the recipient was noted to be quiet, calm, pleasant and cooperative in the meantime. Nurses seemed to reflex to emergency administrations, as best said by the nursing manager, you have to follow an order. So there were no documented attempts or considerations for less restrictive measures when continuing emergency doses after the redeterminations. In the instance this writer witnessed, that was exactly the case in addition to the fact that there was absolutely no potential serious and imminent physical harm going on when she was medicated at 11:00 a.m. on the 7th. The restriction notices provided confusion on exactly what information was provided about the recipient's contact person; one listed just the first name, another the full name, while others included explanations that there was no address to send the notice. The violation comes in the October 5th notice from 11:30 a.m. that stated the form was provided to the designated person when it was not, that the forms provided to the recipient and the Guardianship and Advocacy Commission were unable to be read, and, that a form was received eight days after the incident. This is not receiving proper notice per the Code and Singer policy. The complaint that Singer did not follow requirements for administering emergency medications is substantiated.

RECOMMENDATIONS

1. Always provide written drug education whenever services include the use of psychotropic medications (405 ILCS 5/2-102 a).
2. Stop continuing emergency medications without documented need. Repeating documented reasons from initial determinations does not justify an ongoing emergency and the record should reflect the need to prevent serious and imminent harm as observed at the time the treatment is needed (405 ILCS 5/2-107).
3. Each restricted right to refuse medication must be met with less restrictive alternatives and any designated preferences given due consideration (405 ILCS 5/2-107 and Singer policies).
4. Instruct staff to sort out discrepancies on restriction forms immediately. This is to protect recipient rights, and all forms should consistently explain why designated persons cannot be contacted (405 ILCS 5/2-201).
5. Provide restriction notices to designated contacts promptly (405 ILCS 5/2-201). Instead of relying on the mail, Singer should call the Guardianship and Advocacy Commission, use the fax machine (815) 987-7227, or walk the notice over since we are just across the street.
6. Provide legible notices (405 ILCS 5/2-201).
7. Formalize training for nurses and physicians and ensure that *all* required steps under 5/2-107 are followed in every emergency instance.

SUGGESTIONS

1. Standardize nursing assessments for emergency medications on a template for the progress notes. This template should include less restrictive interventions that were considered or attempted and recipient intervention preferences--similar to the information on twenty-four determination forms.
2. In formalized emergency medication training, physicians and nurses should be instructed to refrain from using unqualified and unspecific language when assessing need. Danger to self and others, agitated, resistant, combative, manic, delusional, uncooperative, inappropriate and argumentativeness without further descriptive explanation do not equal the need to prevent serious and imminent physical harm.
3. Nurses should always include times entered on all progress notes including emergency assessments provided to physicians.

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*

Illinois Department of Human Services

Grace Hong Duffin, *Acting Secretary*

H. Douglas Singer Mental Health Center
4402 N. Main St., Rockford, IL 61103-1278
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Erin Wade, PhD, Chairman
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main St.
Rockford, IL 61103-5202

September 30, 2010

Re: 10-080-9005

Dear Doctor Wade:

The code and program policy do not require a new event prior to each administration of medication or each redetermination which is implied in the investigation findings. The code does not delineate specific time frames associated with "imminent." It appears that there is a significant difference between the Human Rights Authority and Singer in interpretation of "imminent." Historical use of the term imminent demonstrates the risk of assigning a specific time frame. In the Federalist Papers John Jay writes, "It is not yet forgotten that well grounded apprehensions of imminent danger induced the people of America to form the memorable Congress of 1774." Our forefathers began taking steps to prepare for that imminent danger and continued that preparation even though there were no doubt days when there were no acute signs of danger. The code clearly grants the physician the responsibility to determine that danger is imminent and for determining that the danger continues. In this case the physician clearly documented his ongoing concern. Continuing medications until the circumstances contributing to the assessment are resolved is not only prudent medical practice but necessary for safety. The code clearly allows Singer staff to consider the potential impact of discontinuing medications when determining if it is safe to discontinue emergency medications. The factors such as refusal of treatment, unwillingness to consider or discuss voluntary medication, recent provocative behavior toward other patients and impulsivity combined with extremely poor judgement were taken together to determine dangerousness. Singer is committed to providing a safe treatment environment while minimizing the need for emergency medications. Typically less than 5% of patients receive emergency medications and most are for less than 72 hours.

RESPONSE TO RECOMMENDATIONS

1. Singer agrees that there was not proper documentation of provision of written drug education and will modify the Initial Determination form to trigger that documentation.
2. Singer will continue to document the need for continuing emergency medications. Singer disagrees with the view that additional dangerous behavior is required prior to each administration of medication.
3. The code does not require documentation of less restrictive alternatives for each dose of

medication. The less restrictive alternatives are included on the Initial Determination and Redetermination forms. Singer will include the need to improve that documentation as part of formal training. Singer will also include the need to give due consideration to alternatives as part of the training.

4. This appears to relate to the confusing, incomplete and inconsistent information provided by the individual regarding who she wanted to be notified of restrictions and how those persons might be contacted. Singer staff were unable to resolve discrepancies with the individual and the individual did not complete a Release of Information form. Singer staff will be instructed to note on the form that the individual did not provide sufficient contact information and/or authorization to facilitate notification.

5. Singer will instruct staff to fax the notice to the Guardianship and Advocacy Commission.

6. The forms are in duplicate and it appears that the bottom form was not impressed properly. Will determine if there is a problem with the form itself or the writing surface used. Will instruct staff to use the copier machine if the "carbon" is not clear.

7. Formalized training has been initiated for nurses and physicians. Suggestions #2 and #3 will be incorporated into the training.

Sincerely,

Mohammad Yunus
Hospital Administrator