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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 10-090-9032
Robert Young Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at the Robert Young Center. Complaints alleged the following:

1. Robert Young Center did not adequately explain the admission process.
2. Robert Young Center did not communicate adequately with the patient. The patient was at the Center for a month without knowing why she was there.
3. Robert Young Center forced medication, without due process, on a patient even though the patient refused.

If found substantiated, the allegations would violate Mental Health and Developmental Disabilities Code (405 ILCS 5).

The Robert Young Center is a community mental health center that typically serves Mercer and Rock Island counties. They serve 9,000 individuals per year through outpatient and inpatient treatment, including a chemical dependency treatment program. The Robert Young Center has 200 employees including psychiatrists, registered nurses, licensed practitioners, Master's level and Bachelor's level case managers, and Qualified Mental Health Professionals (QMHP). This review focuses on the adult inpatient program, an affiliate of the Trinity Medical Center in Rock Island.

To investigate the allegations, HRA team members met and interviewed the Robert Young staff and reviewed documents pertinent to the case. All documents were reviewed with written consent.

COMPLAINT STATEMENT

The complaint states that on February 13th, a patient was brought voluntarily to Trinity hospital in an ambulance. The complaint further states that the patient was taken upstairs to Robert Young to "stabilize" and was allegedly told she was just going to be there overnight; then the next day was told she could not leave. The complaint states that Robert Young told a patient

that she was involuntary but never explained to her that she could not leave whenever she wanted. The complaint states that a doctor told the patient she would be there 3-7 days and she was in Robert Young for a month without knowing why she was there. She was reportedly in Robert Young from Feb. 13th until March 10th before being given a paper to sign to go to court. Finally, it is also said that a patient was given medication even though she refused to take it.

FINDINGS

Interviews with the Robert Young Center staff

The HRA began its investigation by interviewing the Robert Young Center staff. The Robert Young Center staff began by explaining that the patient was voluntarily admitted into Robert Young on 2/10. She was in Robert Young for 24 hours but was not suicidal or homicidal so they discharged her. On 2/13, the patient was brought back to the Robert Young Center because she was hallucinating and had threatened someone. Upon reevaluation, the staff realized that she had escalated to delusional and violent behavior so she was admitted again. The second time the patient was admitted was also voluntary. The Robert Young Center staff explained that they had no record of the patient desiring to return home during the first two weeks at the Center but, after the first two weeks, she wanted to go home. During the first two weeks, the patient only complained about her c-section and pregnancy, even though she was not pregnant. The staff explained that the patient did not understand that she was there for anything more than her pregnancy, even though she was not pregnant. The patient began fluctuating in taking her meds and starting acting out more after the first two weeks. The staff stated that the patient acted out to the point where she had to be restrained, and a week later, on March 3rd, she asked for 5-day paperwork to be discharged from the hospital.

The Robert Young staff told the HRA that the patient would say that she wanted to leave the hospital but then would ask for help with her baby. The staff pointed out that the patient was pretty spirited when she was not violent. The court eventually admitted the patient involuntarily, and then later the patient was court ordered to take medications. Finally, the patient petitioned to move to a skilled treatment facility and left the Robert Young Center. The staff stated that the patient had to have emergency medication on March 1st and March 30th.

The staff proceeded to tell the HRA that there is a care plan team for each patient. The team consists of two case managers and a social worker. The care plan team involves the patient in the review and they are to have the patient sign the care plan. The team meets with the patient every 72 hours. The staff explained that this patient never challenged the plan and never really got vocal until babies were discussed. The care plan team set goals for the patient, such as changing her aggressive behaviors and not getting aggressive with the staff. The Robert Young staff stated that she signed some of the treatment plans, but not all of them. She was involved with the care plan team and definitely involved in her initial plan. The Robert Young staff explained that the nurses periodically would provide patient education, which would cover topics such as medications, falling while on the ward, and other topics of that nature. The staff also stated that a case manager follows the patient through his/her stay at the facility as a point person. The case manager would help them with discharge, case plan, and other actions of that nature.

The Robert Young staff stated that the patient signed her 5-day notice on 3/3 and the fact that she knew enough to initiate the form speaks for the communication that she was receiving from the hospital. The staff said that the patient was escalating for a week before she signed the paperwork. The staff stated that they did not like that there was no tagline in the nurses' notes or doctor's notes stating something along the lines of "5 day was explained and signed." The patient's doctor had a note from the patient saying that she wanted to be discharged. At admission, the patient saw the initial crisis intervention form and she was also explained her rights. The general process for admission would be giving the patient the crisis intervention form, and then if the patient was admitted, he/she would sign the voluntary admitting form, and then the patient would be given rights information. The staff also stated that the physician's progress notes say that he talked to the patient and discussed her options with her regarding her being admitted into the facility.

The Robert Young staff stated that there is a chance that the patient could have been told that she just needs "stabilized" and that she would just stay overnight because that is the hope when someone is admitted. They said that an example would be to admit the patient and get them back on their medication and then release them. The staff explained that it is standard to communicate to the patients that their stay should be 3 to 5 days and they also stated that Robert Young's average length of stay is 5 days. In this case, the doctor was not willing to discharge the patient on the 13th due to her condition. The original plan with the patient was to discharge her home but the hospital decided that she would need additional care elsewhere.

The Robert Young staff said that the patient's treatment plan would have told the patient her goals that she needed to meet to be discharged but the patient was not listening to goals and was more invested in her delusion about being pregnant. During group sessions, the treatment plan team would meet and discuss the goals. The patient in this case did not want to go to group and was more concerned about pregnancy and babies. Nurses on the floor would also focus on the goals from the treatment plan with the patient. The treatment plan is goal based and each goal has a date for achieving the goal, so dates were involved in the patient's treatment. Robert Young also explained that the patient would have doctor's meetings and at these meetings, the patient's rights were communicated to her. The staff said that even though the patient thought that she was there because of a pregnancy, she knew that she did not want some medication and she understood the patient rights that were explained to her. The staff said that they offered her medication voluntarily and some medications she would take and some medications she would refuse. The patient was given medication twice against her will and she was given these medications when she was assaultive towards the staff. The staff also said that they usually do not do PRNs (as needed) with patients but this patient had PRN medications when admitted. When patients are admitted to the hospital, they have a form that describes what helps them when they get out of control. This particular patient did not really give them any options on the form. When the patient was given forced medication, they tried to redirect her before she was given medication. After the date of 3/15, the patient was court ordered to take medication, so they did not need to fill out a restriction of rights form after that date for giving her medication. The staff also said that every time the patient refused medication, they documented the refusal.

The Robert Young staff went on to say that security is a support for the staff. If a patient does not want to take medication, they will sometimes take medication when they see security. The staff said that often they will call the security staff very early when a patient is starting to act out, so security has a presence there from the start. They also said security makes rounds twice a shift and their office is close to the behavioral health unit so, in general, their presence is in the unit often. The staff explained that they do not use seclusion at the behavioral health unit and they really do not like to use any restrictions. They teach staff de-escalation techniques to avoid using any restrictions. They also stated that staff injuries have gone up due to the fact that they have tried to stop using restrictions whatsoever.

Interview with Security

The HRA also interviewed a Robert Young Center security staff member. The security staff member stated that they are usually called in emergency situations when patients have stated that they will not take medications. The staff member stated that the nurses will tell the patients that if they do not take medications, then security will be called to get them to take medications. The staff member also stated that security may just be called for a patient acting out, and when they get to the unit, they will find out that the situation is an emergency. They also stated that sometimes they know the situation is an emergency ahead of time. The security staff stated that something precipitated the event, like an act of violence. When the guard shows up, they give them an option on how to take the medication. The security staff stated that this does not happen often, and that they get 2 or 3 calls a week for violent patients.

The security staff member stated that with the patient in this complaint, he was called a couple of times, and they were emergencies. He stated that the patient would act out inappropriately and they were called for a PRN. When the security staff was called, the emergency drug was usually administered. The security staff member stated that this is for emergency drugs and not scheduled drug situations.

The security staff member stated that sometimes security is called and the patient does not have to take medications because the situation has de-escalated. He stated that often they are calling with the idea that they may have to give the medication involuntarily. He also stated that just by security showing up, there is often a change in the patient's behavior.

The security staff member stated that they try de-escalation techniques often, and they will try the techniques sometimes if the patients are not actually being a threat. The security staff member will go into the room with the patient when meds are taken to assist. He stated that sometimes they will help the patients lay on their sides to take the medication and sometimes the patient will ask that they hold their hands.

The security staff member stated that staff, and not security, determines an emergency situation. Once they get to a situation, security can use their own judgment regarding what to do if the situation has gotten out of control. They stated that there has only been one complaint regarding use of force with the security staff.

The security staff member stated that they receive training in de-escalation. They receive crisis intervention training annually by a security department supervisor and also receive training through a video titled "Verbal Judo" which deals with de-escalation techniques. The crisis intervention training mostly covers de-escalation when an individual is in crisis and how to redirect the situation before it turns into an emergency. Examples of other topics in the training include the application of restraints, handcuff training, and mace training. The security staff member stated there are no training elements dealing with the Mental Health and Developmental Disability Code other than restraints and the training does not cover individuals with mental health issues. A Robert Young Center staff member did state that there are in-services with the staff and case managers concerning mental health rights, restraints, and certification and that, at the last training, the facility's security manager was in attendance.

Record and Policy Review

In regard to the complaint that the patient was not adequately explained the admission process, the hospital's voluntary admission policy states that "At the time of admission, the RN, crisis evaluator or doctor conducting the admitting interview will fill in the requested information on the Application for Voluntary Admission … The contents of the form will be read aloud and verbally explained to the admittee and/or responsible person who accompanied the patient to the hospital, as well as the rights of the voluntary patient, by a professional staff member." It is also written in the form that "In the space provided for reasons why the admission is voluntary, an RN, crisis evaluator, or doctor must write in the reason(s) for voluntary admission." In the section reading "I certify that the above person has been examined and is considered clinically suitable for voluntary admission. The individual is not suitable for informal admission for the following reasons" and the reason is written as "Incomplete thought process." The form also states "The admittee or responsible person will sign the application in the space provided." The voluntary admission form for the patient's 2/13 admission is signed by the patient. The voluntary admission form reads "I have been informed of the 'Rights of Voluntary Admittee' as explained on the back of this form. I have been given a copy of the 'Rights of Individuals' which states in detail of my rights as an individual receiving services." The "Rights of Voluntary Admittee" form that is on the back of the admission form states "You have the right to request discharge from this facility. Your request must be in writing. After you give your request, the facility must discharge you at the earliest appropriate time. This time may never exceed 5 days, excluding Saturdays, Sundays, and holidays, unless it is expected that you are likely to inflict serious physical harm on yourself or others in the near future. If the facility director believes you are likely to do harm yourself or others, he/she must file a petition and 2 certificates with the court within the same 5-day period. You will then have a hearing in a court and the court will determine if you must remain at the facility." The HRA also reviewed the patient's "Psychiatric Voluntary Admission" form which was signed by a physician on 2/13 stating that the patient has the capacity to consent to voluntary admission.

The HRA reviewed the patient's "Request for Discharge" form. The document is signed on 3/3 by the patient and reads "I am requesting discharge from this facility." The document also states "I understand as a–voluntary patient, I will be allowed to be discharged at the earliest appropriate time, not to exceed five (5) days excluding Saturdays, Sundays and holidays." The form does not mention the petition for involuntary admission process.

The HRA also reviewed Robert Young's petition for involuntary admission that was filed in the Rock Island Circuit Court. The date of the petition is 3/9/10 and it was filed during the 5-day span (not including weekends) after the patient requested her discharge on 3/3/10. The court order for the patient's involuntary admission is issued on 3/15/10 and states "That the Respondent, [Patient's name] be involuntary admitted to the Robert Young Mental Health Center, Rock Island, Illinois, for treatment of her mental illness." It is also stated in the document that the duration of the order is stated in 405 ILCS 5/3-813, which states that the initial period of commitment will not exceed 90 days. The 90 days did not exceed the time that the order was given on 3/15 to the time the patient left the facility on 5/13. Along with the court order for involuntary admission, there is a court order for the administration of psychotropic drugs which is also dated 3/15/10. The drugs that are ordered for the patient to take are Risperdal Consta (long acting), with alternatives of Risperdal, Ambien and Cogentin. The order is for up to 90 days which, like the commitment order, was not exceeded from the time the order was given on 3/15 to the time the patient left the facility on 5/13.

Within the petition, there is a signed statement saying that the patient received copies of the petition within 12 hours of admission into the facility.

The HRA also reviewed a policy titled "Admission to Inpatient Mental Health and Chemical Dependency Services." In that document, it states "Upon admission the admitting staff will ensure that all admission documents are signed by the patient and/or guardian and read and explain the patient's rights to the patient and the guardian." The policy also states "An orientation to the unit is completed by a behavioral health technician including review of the patient handbook for the appropriate unit."

The HRA reviewed nursing notes on 2/16 which noted that the patient said "I was told I only have to stay here for 3 days. Why can't I go home?" According to the nursing notes, on 2/24, the patient stated "I don't need to be in here. I don't have a problem. I'm fine."

Throughout the documentation, there are examples that the patient did understand that she could request discharge. A nursing note from 3/4, reads "… asking questions about 5 day.'When will I get out? When is the 5 day done?' This staff shared with pt that it didn't count weekends or holidays. When aprox [sic] 15 seconds pt looked at this staff and said 'oh that means this coming Tuesday.'" Another nursing note from 3/9 reads "Pt became very angry and upset when this nurse informed her that [Doctor's name] did not feel that she is safe enough to go home, and that he is filing a certificate with the courts because her 5-day is up today. This nurse attempted to explain to the pt that the procedure would be for the certificate. Pt began yelling and cursing at the staff."

In regard to the complaint that the Robert Young Center did not adequately communicate with the patient and that the patient was in the facility for a month without knowing why she was there, the HRA began by reviewing the patient's Individual Treatment Plan, which was signed by the patient on 2/17. The date of the initial treatment plan meeting was 2/13. The plan has a section which reads "Projected Discharge Date" and the date in that section is "2/18." In the "Level of Participation in Discharge Planning" section, it reads "Unable to participate at

[illegible] of admission due to psychosis." In the "Level of Participation in Treatment Planning Session," under the "Client Participation" section, it reads "Pt agreed and signed." In the "Client Goals While Receiving Inpatient Treatment" it states "Pt to comply with all scheduled medications" and "Pt to demonstrate decrease in delusional thoughts." In a subsequent Individual Treatment Plan review, the "Barriers to discharge" section has barriers such as "delusional" and "psychotic" along with the dates that the treatment plan met. With every barrier, there is a "Plan to Overcome Barrier" such as "Adjust medication" or "Medication management." Other documents in the review describe a problem area, short term goal, interventions, evaluation, and caregraph score. These documents keep track of the different goals that the patient had while at the facility and dates or progress of the goals. Other than the initial treatment plan, there is no patient signature on the forms.

The HRA also reviewed the doctor's progress notes regarding the patient. On a progress note dated 2/18, a line in the notation reads "She was given an opportunity to ask questions and address any issues during the session." A doctor's progress note from 2/19 also states that "The patient was given the opportunity to ask questions." On 2/22 the same statement was made in the progress notes. Between the dates of 2/18 and 5/13 there were 29 occasions noted in the doctor's progress notes where the patient was given an opportunity to ask questions and address issues. There are other examples in the physician's progress notes of the doctor when speaking with the patient about her involuntary court date. One occasion was on 3/14 the physician states that he discussed the next day court date with the patient and also on 3/15; the doctor states that the involuntary commitment process was discussed with the patient.

A Nursing Note from 3/15 states “Patient left court after it ended and burst out into the hall yelling and making threatening statements.” The note indicates that the patient participated in the involuntary court proceedings. Another Nursing Note from 3/9 states “Pt became very angry and upset when this nurse informed her that [Physician’s Name] did not feel that she was safe enough to go home, and that he is filing a certificate with the courts because her 5-day is up today. This nurse attempted to explained [sic] to the pt that the procedure would be for the certificate.”

Further documentation that the patient was communicated with regarding her stay at the facility exists in the Case Manager notes. One Case Manager note from 4/14 states "Grandmother [Grandmother's name] and friend [Friends name] here to visit [Patient's name] after visiting [Mental health facility]. [Patient's name] became very angry and agitated. Accused grandmother of trying to poison her and taking her home away from her … Met with [staff, grandmother, and patient] to discuss options, [Patient's name] interrupted several times, but redirected. Only wants to go home, no other options acceptable to her." Another 4/30 Case Manager note reads "Discussed with patient transferring to [Mental health facility] for continued care. Pt. very resistant became very volatile. Security call and IM medication administered to decrease agitation."

In a progress note, written by the patient's physician on 3/9/10, the physician writes in the "Plan/Recommendations" section that "We will continue to encourage the patient to take her medication. We will continue to encourage her to work with the treatment program. However, if she continues to move in the direction in which she has been moving, we will need to be

considering possibly transfer [sic] to a state facility. I have talked to the patient about this and she is refusing to acknowledge any sort of other options other than just getting out and going back on the streets and doing what she wants to. This particular patient has a potential for violence as demonstrated in the past and we are trying our best to work with her to stabilize her condition at our facility. I have been in touch with the discharge planner, [Discharge planner's name] and have discussed this with him as well as with the nurses that are involved in her case and we have one goal in common and that is to be most therapeutic in helping her to achieve some type of stability and letting her get on with her life. I discussed this with her, but at this point in time she is not willing to listen to any other options other than having the program work the way she wants it and is not willing to cooperate with us."

In the nursing notes on 3/30, it states "Clients grandmother [sic] calls the unit and states that client called her and told her that she was being discharged today, she told her grandmother that her mother was going to come and pick her up today. Client is insistend [sic] that she is going to go home today and she argues with the nurse concerning this subject. Client is encouraged to speak with Dr. concerning this. Client sees Dr. in early afternoon, Dr. informs her that she is not going home, client acknowledges this information, stays in her room the rest of the day."

Nursing notes from 3/16 read "Pt has been demanding to sign a 5 day notice, explained to her she was there involuntarily and no longer able to do that. She stated in court that they told her she could appeal the decision, attorney's number provided to her and she left a message."

On the "Behavioral Advance Directive; Assessment to Assist with Minimizing the Use of Restraints" form that is signed by the patient, it reads "Our goal at Robert Young Center is to provide a safe and supportive environment. Your safety and the safety of others is important to us. If you become angry or upset, staff are available to talk and find ways to help you solve the problem. We encourage you to choose the best way to manage your anger . . . We ask you to make a commitment to tell staff when you need help to manage your feelings or anger, and work with staff on remaining in control." For question 3 on the form, which states "What approach (techniques or tools) would you like us to try to assist you to remain calm or control our temper when stressed or angry?" it is written that "[Patient's name] redirected verbally to her room."

In regard to the complaint that the patient was forced medication, the HRA reviewed rights restriction notices from 3/1/10 and 3/30/10. On 3/1/10, the Restricted Rights form states that the patient received emergency forced medication for "Threatening staff. Attempted to hit a staff member." The record states that the patient's rights were restricted from 1817 to 1818 on that day. The nurse's notes from 3/1/10 states "Patient extremely labile this shift and confrontational with staff. Patient has been rapidly walking around the unit and appears to be responding to internal stimuli. Witnessed talking and arguing to herself. During dinner, patient had refused the food that had been served to her … She then threw her tray back into the slot in the food cart. A few minutes later, patient retrieved her tray and sat down to eat. Later, patient approached the nurse's station and accused staff of starving her. She put her arms on the edge of the desk and lifted her body of [sic] the ground. She began to make threatening statements toward staff. Staff attempted to redirect patient to her room but patient continued to make threatening gestures to this nurse. 'I am going to punch you in the face.' Patient not listening to

staff direction. Very agitated and aggressive. Staff was able to escort patient to her room. Security contacted and Ativan, Haldol, Cogentin given IM at 1817 against patient's will. Patient had to be physically restrained by security for less than one minute."

The second rights restriction document, dated 3/30/10, states that the patient received emergency forced medication and had certain rights restrictions for the duration of 0230 to 0232. The document also has "Court ordered for medications" in the "Other" section of the document. The document states the reason for restriction of rights reads "Agttated [sic], physically confrontative [sic] to staff. Escalating behavior." Nursing notes on 3/30 state at 10:29 "Pt still very aggressive toward staff and other patients, requiring PRN IM's to calm her down. Singing loudly, disruptive. Will discuss plan with MD regarding next level of care." At 16:11 of the same day, the nursing notes state "Patient came to the desk at 1540 and started asking where is her discharge papers. Patient was informed that she was not going to be discharged. Patient then stated that she was going to kick someone's ass. Patient then went down the hall came back and ripped the sheets off the bed in the hall. She then pulled the mattress off the floor. Patient was asked to stop and she kept doing it. Patient had to escorted be by security to her room to receive IM medication. Patient became irate was cursing, yelling, threatening staff. Patient was then given IM Haldol 5 mg, Ativan 2 mg, and Cogentin 2 mg. Patient had to be held for the injections. Patient afterwards went to the community and was heard threw [sic] the door screaming and yelling. Patient was asked to leave out and had to be escorted out by security."

The Nursing Notes from 2/13 state "Pt up on unit. Pt pacing in hallway. Pt talking to herself, singing very loudly, and yelling at other patients. Pt became increasingly agitated this morning and unable to calm herself down. Geodon 10mg IM and Ativan 2mg IM given at 0900. Security was called, but pt accepted the IM's willingly. Pt was very upset and angry after the injection, stating, 'I'm going to sue you all for giving me this injection. I'm pregnant.'" On 2/18 the Nursing notes state "One minute patient is sweet and apologetic, the next minute she is loud and curing [sic] at staff members. Stated that she wouldn't threaten staff because she would go to jail. Patient was warned that if she continued to be verbally aggressive with staff … [sic] Patient approached staff about twenty minutes later and asked if she could enter a number in her phone. Patient was told it would be a few minutes. Patient became agitated and demanding. Proceeded to call staff names and curse. Patient would not redirect. Security called. Administered Ativan and Geodon given intramuscularly. Patient shouted and complained that the medication burned." On 3/9 the Nursing Notes read "Pt began yelling and cursing at staff. Pt stated, 'I don't care. I will go to jail. I am going to punch someone.' Pt began pacing in the halls, and very hyperactive. Security called to the unit. Ativan 2 mg IM, Haldol 5mg IM, and Cogentin 2mg IM given to pt. Pt willingly accepted injections from this nurse."

According to the medical log, Haloperidol with Ativan and Cogentin, were given for "Moderate Agitation/Psychosis". Between 2/27 and 5/7, Haloperidol Lactate was given with Ativan and Cogentin for "moderate atitation[sic]/psych" 21 times with no refusals and an Ativan injection was given 33 times between 2/13 and 5/7 with no refusals. As stated earlier, Ativan was a primary drug given when the security was present.

In reviewing the patient's "Discharge Medication Administration Profile" it shows the medication that the patient was offered and what was taken. For example, Quetiapine Fumarate

was attempted to be administered to the patient 22 times between 2/26 and 3/19 and the medication was shown as "refused" for all 22 attempts. Benztropine Mesylate (Cogentin .5 mg) was to be administered 77 times and the medication was refused 19 times. Benztropine Mesylate (Cogentin 1 mg) was to be administered 47 times between 3/5 and 5/3 and it was refused 6 times during that timeframe. In accordance with the psychotropic medication court order, Cogentin was one of the alternatives to the first choice of Risperdal Consta to be given to the individual. The patient was to be administered Clonazepam 52 times between 2/27 and 5/16 and the medication was refused 43 times.

After the court ordered date of 3/15/10, the patient was compliant with the Risperdal Consta except on 4/13 the patient refused and the reason given was "Refused to take 75mg because of court order stating that she only has to take 25-50mg q 2 week. 50 mg was given."

Between 2/15 and 5/10, the patient refused short-acting Risperdal (which is another alternative to the first choice of Risperdal Consta on the court order), in various doses (between 1mg and 3mgs), a total of 38 out of 150 attempts to administer and 19 of those refusals were after the court ordered date of 3/15. Ambient was refused 44 out of 46 attempts to administer. Ambient is also on the court ordered list of alternative medication.

Also, in reviewing the “Discharge Medication Administrative Profile,” before each medication was given there is a section of the document which reads “Patient Education Provided for Food and Drug Interaction.” In that section, it is indicated this education was given to the patient and that print instructions were given regarding purpose of the drug, schedule, and special instructions, as well as food and drug interactions and side effects or signs and symptoms to report. In a conversation with Robert Young Center staff, this is also the area considered to be where informed consent is given. The HRA did not find evidence in the documentation that the patient’s capacity for understanding the medication was recorded in the patient’s file.

In reviewing the nursing notes concerning the Ativan, Haldol, and Cogentin, on 2/24 "Pt was given Geodon and Ativan injections at 1245 today" with no comment on whether the injections were taken voluntarily or not. On 2/28 "IM Haldol 5 mg, IM Ativan 2 mg, and IM Cogentin 2 mg given as per order," again with no comment on whether the injections were taken voluntarily or not.

MANDATES

The HRA reviewed mandates in accordance with the complaints. The Mental Health and Developmental Disabilities Codes states "(a) Any person 16 or older, including a person adjudicated a disabled person, may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director of the facility if the facility director determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission. (b) For purposes of consenting to voluntary admission, a person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the person is able to understand that: (1) He or she is being admitted to a mental health facility. (2) He or she may request discharge at

any time. The request must be in writing, and discharge is not automatic. (3) Within 5 business days after receipt of the written request for discharge, the facility must either discharge the person or initiate commitment proceedings" (405 ILCS 5/3-400).

In regard to voluntary patient discharge, the Code states "A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates conforming to the requirements of paragraph (b) of Section 3-601 and Section 3-602 are filed with the court. Upon receipt of the petition, the court shall order a hearing to be held within 5 days, excluding Saturdays, Sundays and holidays, and to be conducted pursuant to Article IX of this Chapter. Hospitalization of the recipient may continue pending further order of the court" (405 ILCS 5/3-403).

In regard to the patient receiving petition documentation, the Code reads "Within 12 hours after his admission, the respondent shall be given a copy of the petition and a statement as provided in Section 3-206" (405 ILCS 5/3-609).

The Code also states "(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility" (405 ILCS 5/2-200).

The Code states that "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" (405 ILCS 5/2-102).

Regarding alternative treatments to emergency forced medication, the Code reads "(d) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication or electroconvulsive therapy under subsection (a) of Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's

record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive" (405 ILCS 5/2-200)

In regard to medication capacity and consent, the Code reads “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” (405 ILCS 5/2-102a-5).

The Code states "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" (405 ILCS 5/2-107).

The Code also states “(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record” (405 ILCS 5/2-201).

The Code also states, in regard to patient discharge when under a court order that "(a) Any person committed on an inpatient or outpatient basis on court order under this Chapter or under any prior statute or any person on his behalf may file a petition for discharge at any time in the court of the county where the recipient resides or is found" (405 ILCS 5/3-900).

CONCLUSION

Complaint #1: Robert Young Center did not adequately explain the admission process.

The complaint states that the Robert Young Center did not adequately explain the admission process to a patient who was voluntarily and then involuntarily admitted. The complaint states that the patient was admitted and was told that she would only be at the Center overnight to "stabilize" and then, the next day was told that she could not leave. The Robert Young staff explained that there is a possibility that a patient could have been told that she just needs "stabilized" and that she would just stay overnight because that is the hospital's hope upon admitting a patient. The staff explained that the patients usually stay in the facility on a short term basis (the hospital has indicated a 5 day average stay) and sometimes they are only at the facility to get them back on their medication. In this case the doctor was not willing to discharge the patient the next day due to her condition. The facility's voluntary admission policy states that the staff member conducting the admitting interview fill out the requested information on the form and the contents of the form will be read aloud and explained to the patient. The admission form explains the individual's rights, one of which is the right to request discharge from the facility. The form does not state or indicate any projected date that the patient may be discharged nor is there an explanation on any form that regarding the average length of stay at the facility, neither of which are required. There is a separate form, signed by a physician, which states that they have determined the patient to have the capacity for consent into the facility. The staff stated that the patient was focused on the idea that she was pregnant and did not understand that she was at the facility for anything more than her pregnancy, even though she was not pregnant. The staff also suggested the fact that the patient requested 5-day paperwork indicated that the patient was aware of how the admission process worked. Due to the fact that the patient signed the voluntary admission application and was provided with all required rights information including copies of her petition and those accompanying rights, evidence indicates that the processes were explained to the patient, the HRA finds this complaint **unsubstantiated**, but offers the following **suggestions**:

- The admission paperwork indicates that the staff felt that the patient had capacity to understand the admission process and shared rights information with her. But the staff, and other documentation, indicated at the same time that the patient was delusional, hallucinating and preoccupied with the idea that she was pregnant and was unsure why she was at the facility. This leaves question as to whether she was truly able to take in that information. We suggest that the staff revisit patients some time later when their conditions permit to cover important admission materials again (405 ILCS 5/2-200).
- The staff stated that there is a possibility that the patient was told she was admitted to stabilize and that she would only be there overnight. The staff also indicated that it is standard to communicate to the patients that their stay should be 3 to 5 days. Ensure that while the staff are indicating that on the average, the stays are short term that they are also indicating to the patients that the 3 to 5 days is just an average and there is a possibility that their stay at the facility could be longer.
- It is stated in the nurses' notes that the patient asked to sign a 5-day discharge notice but was told that she could not because she was there on an involuntary basis. In accordance with the Mental Health and Developmental Disabilities Code 400 ILCS 5/3-900, when a patient is under a court order for involuntary admission, the patient may still petition for

discharge at any time. Assure that patients are allowed to petition for discharge from the facility even though they are there on an involuntary basis.

- On 2/16, the nursing notes state that the patient said "I was told I only have to stay here for 3 days. Why can't I go home?" Because the patient was requesting to go home, the hospital discharge documentation, or any written documentation by the patient requested to be discharged, should have been completed and filled on that date. Remind staff to assist in the discharge process as soon as, and whenever, the patient requests to be discharged.

Complaint #2: Robert Young Center did not communicate adequately with the patient. The patient was at the Center for a month without knowing why she was there.

The complaint states that the Robert Young Center did not communicate adequately with the patient and the patient was at the Center for a month without knowing why she was there or that she was there involuntarily. The patient was allegedly in Robert Young from Feb. 13th until March 10th before being given a paper to sign to go to court. As stated before, the Robert Young Center staff explained that the patient was focused only on the fact that she thought she was pregnant and did not acknowledge any other aspects of her stay at the facility. According to the documentation, the patient signed a 5 day notice on 3/3. The petition for involuntary admission was filed on 3/9 and the patient went to court on 3/15 where she was involuntarily admitted to the Robert Young Center. The physician's progress notes indicate that he spoke with the patient on 3/14 regarding the court hearing and nursing notes from 3/15 indicate that the patient attended the court hearing. Also, the Patient's Rights document, which is located on the back of the voluntary admission form, explains the possibility of involuntary admission and gives a quick summary of the process. The patient's Individual Treatment plan also communicates aspects of the patient's diagnosis in the "Barriers to discharge" section of the document, and the patient had signed this document. Also, within the hospital documentation, there are multiple indications of the physician asking the patient if she has any questions or anything that she would like to discuss. Due to the multiple modes of communication with the patient, as well as documentation showing the patient's access to events regarding her hospitalization, the HRA finds the complaint **unsubstantiated**, but offers the following suggestion:

- Going forward, ensure that the staff document, in detail, discussions with patients regarding their status at the facility and what was explained to the patients regarding their status.

Complaint #3: Robert Young Center forced medication on a patient even though the patient refused.

The complaint states that the patient was forced medication even though the patient refused. As illustrated in the report, the patient did at times take medication and, at other times, did not take the medication that was offered. On March 1st and March 30th, the patient was restrained and forced medicated. In those instances, the Robert Young Center filled out the proper rights restriction forms. In the nursing notes, it was indicated that security came to the unit multiple times and the patient accepted medication. No restriction notice was filled out in the instances where security was called and the patient took medication. In one instance on 2/13,

after medication was given with security present, and according to the nursing notes, the patient stated “I'm going to sue you all for giving me this injection.” In the interview with the staff, they stated that sometimes when a patient does not want to take medication, when they see security they will take the medication. In an interview with a security staff member, the security staff stated that the nurses will tell the patients that if they do not take medications, then security will be called to get them to take medications.

The Mental Health and Developmental Disabilities Code states that "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." On 4/30 a Case Manger note reads "Discussed with patient transferring to [Mental health facility] for continued care. Pt. very resistant became very volatile. Security call and IM medication administered to decrease agitation" and on 3/9 the Nursing Notes read "Pt began yelling and cursing at staff. Pt stated, 'I don't care. I will go to jail. I am going to punch someone.' Pt began pacing in the halls, and very hyperactive. Security called to the unit. Ativan 2 mg IM, Haldol 5mg IM, and Cogentin 2mg IM given to pt. Pt willingly accepted injections from this nurse." In accordance with the Code, the medication can only be forced in instances when it is preventing the patient from "causing serious imminent physical harm to the recipient or others," but the language used in these cases describe the patient as "volatile," "agitated," and "hyperactive," and do not indicate serious physical harm.

The Mental Health and Developmental Disabilities Code also states "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 5/2-107). The Code also states “(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under 'An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named', approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record” (405 ILCS 5/2-201).

The HRA has determined that, when security is called because a patient has refused medication and staff has stated that if the patient does not take medication security will force them to take the medication, is a form of coercion and a restriction of rights. The confirmation that this coercion is a practice within the facility coupled with the fact that the patient stated displeasure in the injection on an occurrence, illustrates evidence that the patient was coerced

into taking medication that she did not want to take when an emergency did not always exist; due to this the HRA **substantiates** the complaint and provides the following **recommendations**:

- Comply with the Mental Health and Developmental Disability Code 405 ILCS 5/2-107 in regard to patient medication refusal. Also, assure that when medication is forced that it is only given in situations where "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" in accordance with the Code.
- When it is deemed necessary to force medication, comply with the Mental Health and Developmental Disability Code 405 ILCS 5/2-201 in regard to the rights restriction procedure. This section of the Code needs to be adhered to in any rights restriction situation and not only situations of restraint or seclusion.
- In reviewing the restriction documentation that was filled out for the two occasions on 3/1 and 3/30, the reason for restriction on 3/1 was "Threatening staff. Attempted to hit a staff member" and on 3/30, the reason for restriction on the form was "Agitated, physically confrontative [sic] to staff. Escalating behavior." The nursing notes on those occasions give a far more detailed account of the situation, especially on 3/30. When filling out the rights restriction documentation, assure that the descriptions for the reasons for restriction on the form are as detailed as possible.
- Involve security staff in training regarding rights under the Mental Health and Developmental Disabilities Code and mental health issues.

The HRA offers the following **suggestions**:

- At times in the nursing notes, it is stated that the patient took the PRN medication with no problems, while at other times, the nursing notes stated only that the patient took the medication and does not state whether the patient voluntarily took the medication. The HRA suggests stating that the patient took the medication voluntarily in the nursing notes each time the patient takes medication.
- The facility has a form in which the patient is asked what they want done in an emergency situation, and while this form is useful, it only asks the patient what should be done in the case of an emergency, rather than what the patient's preferences are for intervention. In accordance with Mental Health and Developmental Disabilities Code (405 ILCS 5/2 200) advise the patients the laws regarding forced medication and ask what intervention they would rather than forced medication. Documentation of the patient's preferred intervention, if any, must be noted on the patient's treatment plan and be considered for use. If a patient does not provide a preference at admission, revisit this issue at a later time.

Additional Comments

In reviewing the patient's medical record, the HRA saw no evidence of capacity for medication being documented. The Mental Health and Developmental Disabilities Code reads "(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" (405 ILCS 5/2-102a-5). Due to the fact that the patient's decisional capacity for medication was not documented, the HRA makes the following **suggestion:**

- When a patient is prescribed medication or when medication is added to the patient's PRN, require physicians to document whether the patient has the capacity to make a reasoned decision about the treatment in accordance with 405 ILCS 5/2-102a-5 of the Mental Health and Developmental Disabilities Code.

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 10-090-9032

SERVICE PROVIDER: Robert Young Center

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

X We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

David L. Dupree
NAME

President / CEO
TITLE

March 3, 2011
DATE

February 23, 2011

Mr. Steven Watts, Chairperson
Regional Human Rights Authority
Suite #7, 5407 North University
Peoria, Illinois, 61614-4776

RE: Human Rights Authority Case # 11-090-9032

We appreciate the findings and recommendations of the Regional Human Rights Authority (HRA). With regard to the unsubstantiated complaints we have used the suggestions in their report to improve our processes particularly with regard to patient education and documentation of ongoing patient care plans. We have shared the findings with staff and are doing ongoing monitoring of patient care plan conference documentation as part of chart reviews. This has helped us in raising awareness of the issues outlined in the (HRA) report; in helping patients address treatment issues and their rights, and in reflecting this properly in our documentation.

With regard to the founded complaint we recognize the HRA position that a patient given a choice between taking a medication or that it would be given involuntarily could represent a restriction of rights.

As noted in their report it is specifically recognized that involuntary medication is authorized when "necessary to prevent serious and imminent harm to the recipient or others and no less restrictive alternative is available" This is a judgment call based on the immediate perceptions of staff tempered by their training and experience, with patient and staff safety being of paramount importance.

There was no finding that we failed in getting the necessary emergent order or that medication was given without the proper authorization. With an emergent order staff is aware that the patient's right to refuse is contingent on the perception of the threat of serious and imminent harm and the medication being the least restrictive means to prevent that harm. The question then becomes is the patient actually taking the med voluntarily and is this substantiated in the documentation.

In this case there is evidence as noted in the report of situations in which the patient refused and medication was not given; where the patient was given medication involuntarily and a restriction of rights sheet was filled out; and where patient elected to take the medications which was documented as voluntary. The problem as described in the report arises from this last case when a patient takes it voluntarily but can not refuse the medication and there is question of the voluntary nature. It is this issue that we address with our action plan:

1) As recommended in that report education will be done with security and staff on using the restriction of rights sheet for those situations in which the patient is in effect given a choice of taking medication voluntarily or that they could be forced to take it.

2) The documentation will include an assessment of the need based on the threat of serious and imminent harm and inadequacy of less restrictive alternatives.

3) Issues regarding patient comprehension and compliance will be addressed in the patient care plan conferences.

4) Monitoring of this will be done through review of each restriction of rights form and the patient's chart for compliance with the above criteria and through comparison with emergent medication orders for overall capture of data.

We anticipate at least one month continuous monitoring with spot checks there after and will also incorporate restriction of rights information with on going care plans and patient education.

Mary Peterson
Director, Robert Young Center (Inpatient)

Dr. David Deopere, President
Robert Young Center