FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9010

Jesse Brown VA Medical Center

Case Summary: The HRA substantiated the complaint that the facility did not follow Mental Health Code procedure when it restrained a recipient and administered forced psychotropic medication.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Jesse Brown VA Medical Center (Jesse Brown). It was alleged that the facility did not follow Code procedure when it restrained a recipient and administered forced psychotropic medication. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) and Jesse Brown Policy Memorandum for Restraints (#11-01-12).

Jesse Brown is a 200-bed acute care facility that provides services to approximately 58,000 veterans and contains a 38-bed behavioral health unit.

To review these complaints, the HRA conducted a site visit and interviewed the Staff Attorney and two staff physicians. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

FINDINGS

The complaint in this case centers around the application of restraint and forced emergency medication administered on 6/30/10 on the behavioral health unit.

The patient in this case was admitted as a voluntary recipient on 6/03/10. Her diagnoses are listed as Schizophrenia and Gender Identity Disorder. The recipient's medical issues include quadriparesis (weakened extremities- the recipient can stand for very short periods while holding onto her wheelchair however she is unable to walk), traumatic brain injury, urinary and fecal incontinence, dysarthria (difficulty with speech), and Methacillin Resistant Staphylococcus Aureus (MRSA).

The Progress Notes for 6/30/10 at 12:06 p.m. are included in the record. An entry at 12:06 p.m. made by the psychiatry resident states, "Pt. was seen in milieu. Pt was being aggressive becoming verbally and physically threatening towards staff. Pt was redirected to go to her room however would not follow directions. Pt yelling at staff and cursing profanities and refused to follow redirection to her room. Pt was disturbing to other pts and informed her that would have to wheel her out of the room if she would not leave. Pt escalating and continued to repeat verbal and physical threats. Pt stating 'If you touch me, I will fuck you up.' Informed pt that she needed to leave the milieu because she was escalating however continued to yell, 'If you touch me, I will fuck you up.' At this point pt raised her fists as if to strike a staff member. Attempted numerous times to reason with pt to take a prn ['as needed' medication] however pt would not cooperate. Offered prns however pt continued to refuse. Pt continued to escalate and at this time was placed in 4 point restraints at 12:00 pm on 6/30/10." The Medication Administration Record also shows that the recipient was administered Haldol, 5 mg and Benztropine, 1 mg at 12:07 p.m.

A Nursing Progress Note was added at 12:09 p.m. which states, "'If anyone comes near me I'm going to fuck them up! I'm not going to take any medication, I'm going to do what I want to do!' Veteran states she will continue to urinate in the chair, floors, or where-ever as long as she's in the hospital. Veteran sitting in wheelchair 'saturated' in urine. Veteran refuses to let staff change her clothing; threatening bodily harm if anyone comes near her. Agitated, verbally threatening writer and other staff members when approached; waving her fist at staff when staff tries to remove veteran from dayroom area to her room to change clothing saturated with urine. Veteran has not taken any medication since being admitted to unit; unable to assess skin for any ulcers, redness, etc as veteran refuse to either clean herself or let staff clean her. Veteran not only disruptive to self but disruptive to other veterans as well with her not bathing; being incontinent in milieu and not changing her clothing. Veteran placed in 4 way restraints for safety of veteran and of others. Veteran refuse less restrictive measures prior to going into restraints as: prn medication for agitation, refuse to go to room to decrease stimuli, not following redirection. Will constantly monitor veteran while in restraints. Will continue to offer veteran medication to 'stabilize' her mood. Will do skin assessment; bathe veteran and passive range of motion while in restraints. Veteran to be able to verbalize compliant with tx. While in hospital. Veteran to verbalize reason placed in restraints and express understanding of not threaten bodily harm to self and others before can be removed from restraints." The record shows that the recipient was given a medical examination, she was placed on 1:1 observation, assessed each 15 minutes, and was given a plan for her release from restraints. The recipient's guardian was notified by phone of the recipient's restriction.

The record shows that the recipient refused all medication from the time of her admission as a voluntary recipient (Psychotropic medication Risperidone refused). The record does not contain a physician's statement of decisional capacity, a consent for Risperidone, or Restriction of Rights documents for the restraint or forced medication episodes. On 7/30/10 the recipient was court ordered to take medication.

FACILITY REPRESENTATIVES' RESPONSE

Facility representatives were interviewed regarding the complaint. They stated that attending physicians and residents have a large presence on the behavioral health unit and are there most of the day. The attending physician for the recipient in this case was present for the restraint and forced medication event and assisted the nurses in the restraint process. Staff reported that generally they do everything possible to avoid restraints and for this reason they are very seldom used. When restraints are used, the event is reviewed by the Restraint Team immediately afterwards.

Hospital staff stated that the recipient refused all medication from the time she was admitted. Additionally, the recipient exhibited purposeful urinating throughout the unit and then refused to clean herself or have anyone else clean her. At times she would present with a urine soaked towel that she wrapped around herself and staff reported that the entire unit smelled of urine for the duration of the time she was there. Staff stated that at one time she urinated in the dining area so that a puddle formed under her chair and other patients left because of the lack of sanitary conditions. The unit does not utilize locked seclusion so the recipient was offered to return to her room but she often refused to do so, causing a disturbance throughout the unit. Additionally, staff reported that the recipient often pinched the staff's breasts or punched them when they were near. Staff were asked if they could feel threatened by someone who could not walk and they stated that although the recipient could not walk she was able to hit staff and pick up objects to throw at staff and thus was a danger to herself and others. Additionally, she had many problems with care givers in her home due to her same aggressive behaviors with them, causing problems which threatened her ability to remain in the community.

Hospital staff were interviewed about the documentation required by the Mental Health Code for the use of restraint and forced psychotropic medication. They showed that all the required documentation for restraint is already utilized on the unit, except for a Restriction of Rights Notice. Staff were willing to consider the use of this document, and wanted to note that in this case the guardian was notified even though a formal Notice was not issued. Staff were reminded that the record is missing a physician statement of decisional capacity, a statement of informed consent for psychotropic medication, and a Preferences for Emergency Intervention document. Staff indicated that the facility utilizes a Safety Plan form which allows recipients to identify their high risk situations, how to avoid them and how to manage their behavior should they begin to lose control, however they recognized the value of identifying an emergency preference. Staff noted that they have only been accepting involuntary recipients for two years and the recipient in this case was the first patient on the unit for whom they sought court ordered medication.

STATUTORY BASIS

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their proposed treatments and provides for their participation in this process to the extent possible:

"(a) A recipient of services shall be provided with adequate and humane care and service 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. [Section 2-200 d states that recipients shall be asked for their emergency intervention preferences, which shall be noted in their treatment plans and considered for use should the need arise].

(a-5) If the services include the administration of…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. …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2- 107 [below]…." (405 ILCS 5/2-102).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services…must be informed of the recipient's right to refuse medication… The recipient…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 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…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).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

The Mental Health Code outlines specific directives for the use of restraint. Restraints may only be used as a therapeutic measure to prevent physical harm, based on a physician's written order that states the events leading up to the need for restraints, the purposes for them, the length of time they are to be used and the clinical justification for that period of time. The person being restrained must be observed no less than every fifteen minutes and a record of the observations must be maintained. Whenever a recipient is restrained, a staff person must remain with him at all times unless he is secluded, and he is to be afforded his right to have anyone of his choosing notified (405 ILCS 5/2-108).

HOSPITAL POLICY

Jesse Brown provided the hospital policy and procedure for restraint (Memorandum No. 11-01-12 Use of Restraint Policy). It states that it is the policy of the hospital to provide the patient with the most therapeutic and least restrictive environment which includes a commitment to prevent, reduce, and eliminate the use of restraints. This process begins at admission when

patients are initially assessed for techniques, methods or tools that might help an individual control his behavior Additionally, restraint is limited to emergencies in which there is an imminent risk of a patient physically harming him/herself, staff, or others. The initiation of restraint is made by an RN who contacts the patient's physician or Resident on Duty (ROD) to obtain an order for restraint and to consult regarding the patient's physical and psychological condition. The patient is placed on close observation, family members are notified, and the patient is assessed and monitored each 15 minutes. Within 2 hours the physician must physically examine the patient and notify the Attending MD along with the team members. The monitoring of the patient in restraints includes checking vital signs, circulation, skin integrity, correct application of restraints, patient position and range of motion, nutrition and hydration needs, hygiene and elimination needs, and overall physical and emotional well- being of the patient.

The restraint policy includes the use of Chemical Restraint. It defines chemical restraint as, "The use of psychotropic or hypnotic drugs to control a patient in an emergency situation where there is a substantial risk of serious physical assault or self-destructive behavior occurring or after such behavior has already occurred. This definition involves both those situations which a person receives medication against his/her will as well as those which the person gives consent."

CONCLUSION

The clinical record and the report of staff describes a situation on 6/30/10 in which a recipient became disruptive to the unit milieu and when asked to remove herself from the room refused to do so and threatened staff. The statements of the staff who were present at the time of the event show that the restraint episode may have been necessary (it is less justified in the record alone). There is no Restriction of Rights Notice in the record (for either the restraint or the forced medication) so we do not have a clinical justification for the emergency medication, which is only mentioned in the record and not supported either by the progress notes or staff report. The record is also missing several procedural components of the law regarding psychotropic medication - that the recipient was advised, in writing, of the side effects, risks and benefits of the proposed treatment as well as alternatives, a physician statement that the recipient had the capacity to make reasoned decisions regarding her treatment, and the Preferences for Emergency Treatment form. The HRA substantiates the complaint that the facility did not follow Mental Health Code procedure when it restrained a recipient and administered forced psychotropic medication.

RECOMMENDATIONS

1. Incorporate Restriction of Rights Notices into policy and practice to be used whenever the rights of the recipient are restricted.

2. Review the Mental Health Code requirements for the administration of psychotropic medication and ensure that recipients give informed consent for all psychotropic medications, that physicians complete decisional capacity statements for each recipient receiving psychotropic medication, and that Preferences for Emergency Treatment are completed by recipients and accessible to staff should the need arise.

SUGGESTIONS

1. The facility policy allows for the administration of forced psychotropic medication "to control a patient in an emergency situation where there is a substantial risk of serious physical assault or self-destructive behavior occurring or **after such behavior has already occurred**." The HRA cautions that the use of forced medication after dangerous behavior has already occurred could be construed as punitive and should be avoided unless the recipient presents an imminent threat of serious physical harm.