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# HUMAN RIGHTS AUTHORITY- CHICAGO REGION

## REPORT 11-030-9012
## Northwestern Memorial Hospital

Case Summary: The HRA substantiated the complaint that Northwestern did not follow Code procedures when it administered psychotropic medication to a recipient, however it is unable to substantiate that these medications were a possible cause for the recipient's ensuing neurological problems.

## INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Northwestern Memorial Hospital (Northwestern). It was alleged that the hospital did not follow Code procedures when it administered psychotropic medication to a recipient. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Northwestern is an academic medical center that provides comprehensive care in nearly every discipline. The Norman and Ida Stone Institute of Psychiatry offers inpatient and outpatient services for adults and older adults with mental health and substance abuse issues and its inpatient facility has 29 beds.

To review these complaints, the HRA conducted a site visit and interviewed the Department of Psychiatry Manager, the Associate General Counsel, the Director of Patient Care, and a unit Registered Nurse. Hospital policies were reviewed, and the adult recipient's clinical records were reviewed with written consent.

## COMPLAINT SUMMARY

The complaint involves a treatment episode that began when the parents of the recipient brought her to Northwestern (11/23/10) because she had become psychotic while home from

college for the Thanksgiving holiday. The complaint alleges that the recipient was given emergency medications for no adequate reason and was given so much psychotropic medication that she eventually began to experience seizures. The complaint indicates that the forced medication began because the recipient had an altercation with a nurse and thereafter her medication was increased even though the parents of the recipient complained that she was nauseated, staggering, couldn't use her left arm, couldn't wipe her mouth, and could not walk without difficulty. Allegedly, the parents asked staff one day about the circumstances of one episode of forced medication and they were told, "She was calling out to her Mom and Dad and we didn't want to upset the other patients." Additionally, the parents were allegedly told that if the recipient did not take her medication the hospital would get a court order to force her to take them. On 12/17/10 the complaint indicates that the parents were called and were told that the recipient had been taken to the ICU for a CT scan, a lumbar puncture and MRI. Although the recipient stopped breathing on her own and had to be placed on a vent, all the tests came back normal, causing the parents' concern that her symptoms were the side effect of too much medication.

FINDINGS

The record shows that the recipient was brought by her father to the Northwestern emergency department approximately one week before the above referenced hospitalization. She was recommended for follow-up care with a psychologist, however when she arrived for her appointment, the staff referred her back to the emergency department. Her case formulation states, "20 year old AAF no prior psychiatric history, no medical problems comes in for 2nd time this week on referral from psychologist for possible emerging, new onset psychosis. Patient was noted to be acting differently for the past few weeks per parents and this seems to be progressive. Per family and records, patient's baseline is she is a very good student at Tennessee State and had been not acting like herself: staring blankly, 'in a daze', suspicious, paranoid, anxious, panic attacks, scared of individuals, distractible as she felt she paid cab driver but had not and thus cop had called, unplugged radio instead of just turning it down. They wondered if she was stressed from homecoming week activities, but she progressively seemed to be acting odd. She was seen by psychologist today for the first time on referral from ED where she made comments about feeling like being in a coma and therapist felt she was psychotic and made comments about switching eyes with her father. In the ED, patient quite guarded, suspicious, paranoid initially in enclosed room and kept trying to leave the hospital. On collateral, mother stated patient is calmer later but she is disorganized, repetitive, concrete, suspicious, paranoid, talks about not answering if she is getting special messages from the radio because she doesn't want us to think there is something wrong with her. She denies hearing any voices, but there is increased latency of speech and she tends to question every question the examiner states. Denies SI [suicidal ideation], HI [homicidal ideation]. She does not report any further stressors, denies depression, denies problems with sleep, does report miscarriage in September with last period in July. She reports she did not know she was pregnant and then one day she saw baby in the toilet which she told college nurse about and they sent her to ED where she had ultrasound. Endorses marijuana but no other drugs or trauma." The recipient was recommended for an inpatient psychiatric evaluation and was accepted on a voluntary application for admission on 11/23/10. The recipient signed releases for her father, mother and grandmother to receive all the written and verbal medical information concerning her case.

On 11/24/10 an addendum to the Psych Admission Note indicates that the recipient "appears frightened and with goose bumps on her arms. She states, 'I am scared.' She states, 'I have been having panic attacks. APN (Attending Psychiatric Nurse) asked if last night's Risperdal 1 mg was helpful for her. Patient states, 'no', 'I just want to go home.' ….APN increased Risperdal to 2 mg hs [before bed] and changed formulation to dissolve tab to ensure compliance." At this time the recipient's prescribed active medications included: Risperdone, 2 mg hs, and PRN (as needed) medications of Benztropine, 1 mg PO (orally) every 2 hours, Benztropine 1 mg IM (intramuscularly) every 2 hours, Haloperidol 5 mg PO every 2 hours and Haloperidol 5 mg IM every 2 hours, and Lorazepam 1 mg PO every 2 hours and Lorazepam 1 mg IM every 2 hours. The record shows that the recipient's physician determined that she had decisional capacity (and maintained this determination throughout her stay on the behavioral health unit) and the recipient gave her informed consent for all her medications.

On 11/24/10 at 1:35 p.m. a note is entered into the record describing the first incidence of emergency medication. It states, "Pt. agitated at the start of shift; assuming catatonic positions in day area on several occasions; staring blankly for prolonged periods, arms over head in a pose (ballerina?), unable to distract; when not catatonic, pt. was loud, distraught, sobbing, paranoid, asking same questions over and over 'what is this place?', 'who is that person in my room (roommate)', 'why are the phones not working?' demanding to use the phone at the nurses station because 'my dad is supposed to pick me up!' dramatically yanked her bra from under her shirt, walking all over the unit holding said bra over her head as if to show peers; several peers woke up due to pt's disruptive behaviors; extremely disorganized, labile (hostile stares then giggling next), unpredictable; declined prn meds po, given prn meds of haldol, ativan, and cogentin im with security standby; no physical resistance noted; restriction of rights served; will closely monitor." The accompanying Restriction of Rights Notice is included in the record. The reason for the restriction is stated as: "Extremely disruptive in milieu; loud; taking off undergarments in day area; very paranoid; no redirection." The form indicates that the recipient did not have preferences for emergency treatment and these preferences do not appear on any restriction paperwork.

On 11/25/10 an entry into the Narrative Notes indicates another administration of emergency medication: "Pt. pushed this writer in an attempt to come into the nurses station, Mother and sister were visiting at the time and pt became agitated wanting to leave with them. Pt hit this writer very hard on the forearm shortly after this writer introduced herself to her mother and sister stating she tried to give me medication I didn't want. Pt was offered po PRN medication but refused offered to crush medication as pt stated she had difficulty swallowing pills pt again refused. Mother and sister encouraged pt to take po medication but pt refused. Security was called pt walked to her room and accepted Haldol 5 mg IM, Ativan 1 mg IM and Cogentin 1 mg IM. Pt was asked to stay in her room for 30 minutes compliant with same." There is no Restriction of Rights Notice for this event.

On 11/27/10 an entry in the Psych Reassessment states, "Pt. became agitated, responding to auditory hallucinations (talking to her Mom), received lorazepam 1 mg po; Haloperidol 5 mg IM and cogentin 1 mg IM. Pt. ate lunch and was able to calm down." The note does not indicate

if the medication was accepted by the recipient, however there is no Restriction of Rights Notice for this event.

The first mention in the Psych Reassessment Notes of medication side effects occurs on 11/30/10. Notes state: "Pt. noted 'too many people on the unit.' To appear quite fearful. Observed repeatedly coming to nursing station doorway. Also pt. noted, 'who are those people out their. (sic)' Writer shared with pt that some nursing student on the unit this evening. Pt came into nursing station and sat in chair. To be quite paranoid. 1820 writer offer prn po meds: haldol 5 mg, cogentin 1 mg. pt accepted prn meds. Notice prn meds to be moderately effective. After receiving prn notice gait to be unsteady." On this same day the Psych Progress Note indicates that the recipient had met with her psychologist and that the medication Risperdal had been increased the previous day: "….Patient refuses increase in medication at this time, but Risperdal was just increased to 3 mg yesterday…so will give this a day or two more to show efficacy for psychotic symptoms…." It is not clear from this entry whether the recipient had knowledge of the increase in the medication.

A Narrative Note entered on 12/01/10 mentions increased problems with medication side effects: "Pt complained of stiffness in her left hand stating she was having a reaction from the medication. Pt. states she just got off the phone with her mom and dad and they told her to let the nurse know about her hand. [Nurse] notified and order received for one time dose of Cogentin 1 mg po and scheduled Cogentin increased to 1 mg po BID. Pt states that this has been going on for 2-3 days. Pt has not mentioned anything to this writer about her left hand This writer had 1:1 with pt earlier in shift and pt denied any problems and stated that she was feeling better and was not uncomfortable in any way. Pt told to inform the nurse immediately if she has any reaction to medication or any problem whatsoever. Pt stated she would." On this same day the recipient met with the APN and physician to discuss the course of medication: "APN saw patient with Dr…. today for advice on pharmacology given the fact that patient still appears very paranoid, isolative, as though responding to internal stimuli…. Will increase Risperdal to 4 mg hs for psychosis and will give ativan 1 mg am for anxiety." An addendum added at 5:10 p.m. states, "Met with patient and her family. Educated regarding diagnosis, medications, and course of treatment. Patient's family stated concern over patient's diet and weight loss. They state that patient has lost over 20 lbs in 3 months. APN ordered a nutrition consult per family's request. APN also will order for patient to be able to receive a meal from her family on the unit, as patient states she would eat her grandmother's food. Will further investigate whether patient has a paranoia regarding the food on the unit. At this time, she simply states she does not like the food here. Patient's family requested to speak with Dr… APN's attending for further questions and second opinion. Patient's family also wanted to know why patient's nosebleed was not documented last night. APN told the family she would speak with nursing staff and alert them to this inquiry."

Psych Reassessment Notes entered on 12/02/10 at 11:06 p.m. state: "pt was observed via staff wrapping cord from the computer around her neck while in the north pod. Staff intervene. Pt yelled, 'I do not want to live.' While staff member was attempting to remove pt hands from cord pt to be hostile, agitated, and quite delusional. To be paranoid. Pt was attempting to bite and scratch staff members. 1800 pt was placed in 4 way restraint. Received im meds: haldol 5 mg, cogentin 1 mg, ativan 1 mg. pt was given copy of restriction of rights. pt mom was notified

in person via writer. pt's mom, dad, and grandmother was permitted each 5 minute intervals to visit with pt while in restraints." A Restriction of Rights Notice was issued for this event. The reason is stated as: "Patient took computer cord and wrapped around her neck. To be combative when staff tried to take the cord away from her. To be quite agitated and unpredictable; Also to be paranoid. Pt placed in 4 way restraint. Received IM meds. Cogentin 1 mg, Haldol 5 mg, Ativan 1 mg." The record contains another entry for this day, entered at 11:12 p.m. which states, "Internally preoccupied. to be seclusive to room. out in brief inervals. while out of room notice no attempts to conversate with peers. refused court order po meds. received im meds; haldol 10 mg and cogentin 1 mg to be hyper religious." This entry does not indicate that it relates to the above incident and there is no indication from the record that the recipient ever received court ordered medication.

On 12/06/10 the Psych Reassessment Comments describe some psychomotor retardation: "Prior to family member visiting observed ambulating without any difficulty. notice engaging in conversation with peers. notice not initiating conversation with peers. speech to be clear. while family member was visiting pt position to floor. acknowledge that she could not breathe. [vitals taken]. to appear anxious. extremities to be floppy. pt.'s grandmother expressed concerns. When writer attempted to do pulse on pt continuous moving of finger about voluntarily; also moving of tongue about mouth while staff attempt taking of temp. pt's dad assisted her up from chair to standing position and pull her near to embrace- pt was observed dragging of both feet. tearful after family member left. lack insight into illness. preoccupied with wanting to leave."

Psych Progress Notes from 12/07/10 indicate that the recipient states that her fingers "still shake some…a side effect of risperdal. Patient states that the risperdal is helping her with her mood and her fear, but that she is not able to sleep all through the night. APN discussed adding Seroquel 100 mg hs for insomnia. Patient agreed. Patient denies SI/HI or AVH. Continue Ativan 1 mg daily for anxiety and risperdal 4 mg hs for psychsis. Benztropine 1 mg bid for neuroleptic -induced extrapyramidal side effects of Risperdal. EEG normal." The record then shows that for several days the recipient was improving and thinking clearer with no medication side effects. On 12/13/10 an entry in the Psych Progress Notes states, "….APN talked with patient's mother this am on the phone and patient's mom voiced concern that patient's medicine was causing her to be 'confused' and to have weakness in her left hand. APN talked with patient about this. Patient stated that her left hand did feel as though she could not pick up objects as well as normal and that she thought this was secondary to the medication. APN called a medical consult to address this complaint." Then on 12/13/10 a physician was asked to evaluate the recipient for left hand weakness. "Patient noted for past few days weakness in left hand to point that last night patient had difficulty shuffling deck of cards…." The physician's plan noted only "subtle/imperceptible" deficits in the left hand: "Gross grip strength appear intact though I see how pt notes she has difficulty shuffling deck of cards. In review of side effects of risperdone and cogentin, it does not seem such a focal symptom, if significant, can be due to either of these medications." His recommendation was to complete a follow-up test for metabolic abnormalities with outpatient follow-up. On 12/14/10 an Occupational Therapy Note indicated "In OT physical conditioning groups (last attended 12/10) delayed motor responses persist. Ex. Particularly with multi step instruction, is slow in changing from right to left or combining movements (ex. Head turning and trunk rotation). This is significant as pt. reports 'I was a runner in high school….' "

The day before the recipient was to be discharged on 12/17/10, she began to decompensate: "….Pt. appears withdrawn and more fearful, however, and collateral from other staff suggest this as well. Patient required a prn Risperdal 1 mg this am for agitated and paranoid behaviors. Later, the notes state: "….Pt. is less talkative. Holds back in conversation. Appears paranoid, mildly confused at points, distracted easily…could be product of heightened anxiety or mild paranoia and/or sedation from PRN medication received this am."

Narrative Notes from 12/17/10 describe the onset of the recipient's neurological episode: "Patient was escorted to her room to encourage her to go to bed, at which time the MHW noted that patient started moving around in a circular fashion-spin. Patient then collapsed to floor in MHW arms and it was observed both patients eyes were rolling upwards- eyes rolled back. RN was called at this time. Patient began convulsing as she collapsed. Patient was then noted to demonstrate tonic reaction motions (evidenced by rapid movement of the arms and legs). Patient was then positioned to the floor by the RN…." Shortly after this incident a physician was called to evaluate the recipient's response to commands and she again had another seizure that lasted 30 seconds. After the episode the recipient was nonresponsive and began to get agitated. She was administered 1 mg cogentin and 1 mg ativan IM and continued to have seizures over the next several minutes. The Neurology department was called and then the recipient experienced the third episode of seizures after which she was transferred to neuro ICU.

The record contains the Psych Discharge Notes which describe the Hospital Course: "Patient was admitted to Stone Institute of Psychiatry on a voluntary basis and placed on appropriate precautions. Initial evaluation showed patient to have psychotic symptoms (guarded, paranoid, acting bizarrely) for which she was treated with risperdal which has been titrated up to 4 mg PO qHS by the time of discharge. She was also receiving cogentin 1 mg PO qHS for EPS [extrapyramidal symptom] prophylaxis [to address the effects of risperdal] and ativan 1mg PO daily for anxiety. During initial evaluation, patient also underwent head CT (normal), EEG (normal), as well as routine lab work (normal apart from [positive for cannabis] ). ….Over the course of admission, patient's psychosis appeared to be improving but 2 days prior to discharge had became more withdrawn, less talkative, and had periods of confusion. She was still receiving prn risperdal in addition to scheduled meds. On 12/16, patient acutely developed a fever to 101.3. Covering MD was called to unit and noted [symptom] of headache, nonproductive cough. Fever was thought to be related to viral URI [upper respiratory infection] with concern for influenza…. There was some concern for NMS [Neuroleptic malignant syndrome, a neurological disorder caused by an adverse reaction to antipsychotic drugs] as patient on higher dose of risperdal, however no rigidity was seen on exam…. Later that evening, patient developed what appeared to be a seizure-like episode and MD was called to evaluate patient as well as rapid response. Patient became poorly responsive during and after episodes however was maintaining her airway. Patient was given 1 mg cogentin IM as well as 1 mg ativan IM and continued to have seizures lasting 20-30 seconds over the next several minutes. Neurology was called and witnessed the 3rd episode and requested the patient be transferred to the neur ICU with stat Head CT. monitors were placed after patient was noted to develop tachycardia…. Patient was then taken immediately to head CT and then to neuro ICU." The recommendations include "Dr…recommends all psychotropics including risperdal be held until cause of seizures is clear."

HOSPITAL REPRESENTATIVE RESPONSE

Hospital staff were interviewed regarding each administration of emergency medication. Staff confirmed that the recipient had been very psychotic for her entire hospitalization. Although she reached the point where she was considered appropriate for discharge she continued to be paranoid, confused, and unpredictable throughout her hospitalization (and often very aggressive). Staff were asked how the recipient was able to make informed decisions about her medication when she was unable to take care of her basic needs and continued to hallucinate through her entire treatment episode. Staff responded that the recipient's physician determined that she had decisional capacity and that she was able to make decisions regarding her treatment plan.

Hospital representatives stated that for the occasions when the recipient required emergency medication she was very aggressive and violent with staff, striking out at them when they attempted to de-escalate her behavior and attempting to bite staff. Staff stated that Restrictions of Rights Notices were completed for each emergency administration of medication as well as for the restraint episode and staff noted that all the supporting documentation and Code mandated documentation is in the record. Staff were asked about the comment in the record that the recipient was on court ordered medication. They stated that the recipient was never mandated to take medication and they did not know why this statement was in the notes. Staff were asked about the recipient's preferences for emergency treatment and they stated that because she was very psychotic when she arrived at the hospital she probably did not complete this portion of what is usually the admission paperwork. The preferences for emergency treatment are kept both in a notebook on the unit and also recorded electronically and are always accessible to staff.

Hospital staff were interviewed about the recipient's and her parents' concerns about her prescribed and emergency medication. They stated that the parents were concerned about the recipient's behaviors when they brought her into the hospital because she was acting very psychotic, well before she began her prescribed medications. They also indicated that it is not unusual for a recipient to request an injection instead of an oral medication and that in this case the recipient did have problems swallowing pills. The staff also noted that the presence of security personnel does not necessarily mean that the recipient is forced to take medication - security may be present to ensure that the recipient goes to her room and not that she is being forced to take medication. Staff stated that although the recipient's parents asked questions about what medications the recipient was taking as well as the side effects, they never complained about the use of medications, and never mentioned a connection between the recipient's medication and her interaction with staff. Staff noted that generally, if a parent or family member had a complaint about a medication a staff person would give them contact information for the prescribing physician or a meeting would be scheduled to begin a dialogue with the treatment team. In this case, the parents of the recipient were very involved in the recipient's care and met with the physician on several occasions, giving them the opportunity to express any concerns regarding the medication, however they had no complaint about the medication.

STATUTORY RIGHTS

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 [to prevent harm]…." (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).

## HOSPITAL POLICY

Northwestern policy #5.28 Treatment/Medications: Refusal of Medications states that unless medications are necessary to prevent the patient from causing serious and imminent physical harm to self or others and no less restrictive alternative is available, the patient or the patient's guardian and the patient's substitute decision-maker, if any, has the right to refuse

medications and is informed of this right, in writing on admission. The process for this policy states:

1. Discuss with and present in writing to the patient, and/or guardian and/or substitute decision maker if any, the benefits and potential side effects of taking the medication as prescribed, both short term and long term, as well as alternative services available and the risks of such alternate services, as well as the possible consequences to the patient of refusal of such services.

2. Physician shall assess and document patient's capacity to make a reasoned decision about the administration of treatment (psychotropic medication).

3. Document the patient's reaction and the reaction of the guardian or substitute decision maker if any to the discussion, including a description of the patient's current behavior.

4. Notify the physician of the patient's refusal of the medication.

5. Observe the patient and continue to offer the medication at the prescribed times, without coercion. Document each refusal in the patient's medical record.

Only when a patient's behavior constitutes a significant/imminent threat of physical harm to self or others and no less restrictive alternative is available, may a nurse administer a medication despite the patient's refusal (and in separate policy, #4.0 Rights of Individuals Receiving Mental Health and Developmental Disabilities Services the facility shall inquire which form of intervention the recipient would prefer in these circumstances and this preference must be noted in the recipient's record and given due consideration should it be needed). The nursing staff must also complete a Notice Regarding Restricted Rights of Individual.

CONCLUSION

The clinical record clearly indicates that medical professionals in this case considered the possibility that the recipient's psychotropic medication may have been related to the medical problems that she experienced during her treatment episode. This was only one of a number of considerations, none of which was proven at the time to have a causative effect on the problems that ensued. The HRA however, does not weigh in on medical decisions but on the provider's compliance with the Mental Health Code. To this end, the conclusions to follow will address the portions of the complaint that relate to the Code's mandates.

The Mental Health Code guarantees recipients the right to refuse treatment, including medication, and should the recipient refuse this treatment, it must not be given unless it is necessary to prevent the recipient from causing serious and imminent physical harm and no less restrictive alternative is available. Although the record shows that there were incidents involving imminent physical harm, the record also indicates emergency medication for less obvious reasons. The first incident of emergency medication on 11/24/10 describes the recipient as "loud, distraught, sobbing, paranoid", and states that she was displaying her undergarments in front of peers. Although security was called, there is no physical resistance noted. On 11/25/10 security

was again called and the recipient was "walked to her room" where she "accepted" her injections. On 11/27/10 the notes indicate just that the recipient had become "agitated" and was responding to auditory hallucinations. In these cases there is no description of imminent threat of physical harm and the HRA questions how voluntary an acceptance of medication is with the presence of security who are there for enforcement purposes.

Also, the record does not support the view that the parents did not complain about the recipient's treatment. It is documented in the record that the parents spoke with the APN when they requested a second opinion (12/01/10), that the recipient's grandmother expressed concern about the recipient's emergency medications (12/06/10) and that the recipient's mother called the unit and requested a physician consult regarding medication (12/13/10). Additionally, the record shows, and staff confirmed, that the recipient remained very psychotic throughout her stay on the behavioral health unit, and it is unclear how she was able to make informed decisions about her treatment when she could not attend to her most basic needs. For this reason the support and oversight of her very involved designated family members was very important to the recipient's care plan formulation and for feedback on the recipient's response to prescribed treatment. It is unclear from the clinical record if the recipient's or her family's concerns regarding her treatment were taken into consideration.

The HRA substantiates the complaint that Northwestern did not follow Code procedures when it administered psychotropic medication to a recipient, however it is unable to substantiate that these medications were a possible cause for the recipient's ensuing neurological problems.

RECOMMENDATIONS

1. Review with staff the Code mandated requirements for emergency medication and ensure that emergency psychotropic medication, once refused, is given only to prevent serious and imminent physical harm and no less restrictive measure is available.

SUGGESTIONS

1. The record shows that the recipient was admitted voluntarily into the behavioral health unit on 11/23/10. The following day the recipient requested to be discharged and the record shows that she often stated that she wanted to go home, however she was never provided with a Request for Discharge form. According to the Mental Health Code the voluntary recipient should be discharged as soon as possible within 5 business days of her request for discharge. If she is not suitable for discharge, the proper filing of a petition and certificate with the court are necessary in order to detain and treat her. Review this portion of the Code with staff.

2. On one occasion, 12/02/10, an entry in the notes indicates that the recipient is on court ordered medications although the recipient was never mandated to take medication. This statement brings with it an entirely different directive for the recipient's care and could have severe consequences in terms of the recipient's right to refuse treatment. Review this entry in the clinical record and address it with staff.

3. Ensure that the staff understand that when security is present the recipient likely feels she has no choice with offered medications. Whenever refusing medication is not going to be an option, it is a rights restriction.