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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9017
Chicago Read Mental Health Center

Case summary: The HRA did not substantiate the complaint that the facility placed a recipient in restraints for no adequate reason and refused to clean her after she urinated on herself. Also, the HRA did not substantiate the complaint that the recipient was administered forced psychotropic medication for no adequate reason and that staff was unresponsive to simple requests for items such as bath towels and aspirin.

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 the Chicago Read Mental Health Center (Chicago Read). It was alleged that the facility did not follow Code procedures when it placed a recipient in restraints for no adequate reason and refused to clean her after she urinated on herself. Also, the complaint alleges the recipient was administered forced psychotropic medication because she complained. The recipient also alleges that staff were unresponsive to simple requests for a bath towel, aspirin, etc. If substantiated, the allegation would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Chicago Read is a 190-bed Illinois Department of Human Services (DHS) facility located in Chicago. To review these complaints, the HRA conducted a site visit and interviewed the Hospital Administrator, the Unit Registered Nurse, and the Quality Manager. Relevant hospital policies were reviewed, and records were obtained with the consent of the adult recipient.

FINDINGS

The record indicates that the recipient had been treated at a hospital emergency department and she was then transferred to Chicago Read. At Chicago Read she signed a voluntary application for admission on 1/21/11. Her psychiatric evaluation states "Patient is a 40 year old African American female, divorced 2 years, 1 child, unemployed 2 years, and lives with boyfriend in apartment. Patient was sent to … for insomnia, racing thought, restless and suicidal

ideation, heroin intoxication. Then she was transferred to Read. Patient has recent stress with unemployment, divorce, then she has no money to pay her house mortgage and no medical insurance, cannot pay her medication after the divorce. She has opiate abuse. She reports she has long history of bipolar for 2 years and has been on heavy medication, but her psychiatrist took off her lithium, seroquel, klonopin, 2 weeks ago and she because (sic) insomnia for 2 week and manic, racing thought and dilirours (sic). Then she went to hospital for help." The record indicates the recipient tested positive for opiates and benzodiazepines and that she requested medication to help her sleep. Her Initial Social Assessment states, "The patient has a history of feeling depressed. She was taking psychotropic medications and was seen by a nurse. The patient thought she was taking too many medications and asked her nurse practitioner to take her off all medications. The patient began to have difficulty sleeping. She started to self medicate with alcohol and street drugs. The patient said she called an ambulance when she could no longer manage her ability to sleep. She denied feeling suicidal or homicidal. The patient says she realizes she needs medications now but does not want to be put on a lot of medications at one time."

The record contains the recipient's signed consent for the following medications: Valporex 500-1000 mg per day, Celexa, 10-20 mg per day, Ambien, 10 mg prn (as needed), Seroquel, 700 mg per day, Haldol, 5 mg prn, Thorazine, 2 mg prn, and Klonopin, 0.5 mg daily. The physician's statement of decisional capacity is included in the record. Also included in the record are the recipient's preferences for emergency intervention indicating that she preferred medication for an emergency should it arise.

Progress Notes for 1/21/11 at 11:15 pm indicate that the recipient requested and received Haldol 5 mg, and Diphenhydramine 25 mg im (intramuscularly) because she could not sleep: "Client was very restless, pacing in day room, agitated, and offered prn meds- Lorazepam but client said Lorazepam doesn't work on her Haloperidol works better- didn't sleep for three days. Dr… was notified and got order…" On 2/22/11 the recipient again began to get restless. This time she refused her scheduled medication and requested and received Ativan, 2 mg. po (orally). At 4:00 pm the same day the recipient was placed in restraints. The progress notes state: "Client screaming at desk threatening staff, pounding fists on nursing desk, verbal redirection not effective. Client put in restraints she cooperated. Lorazepam 2 mg IM given client continuing to threaten bodily harm to RN 'I am going to pull out that hair bitch.'" The record contains a Notice of Restriction of Rights for this event. It indicates that the reason for restraints was "client screaming and threatening staff at desk, verbal redirection not effective". It indicates that the recipient did not want anyone notified of the restraint. The restraint flow sheet indicates that the recipient was placed in restraints at 3:54 pm and was removed at 5:15 pm with constant monitoring and 15 minute checks. Restraint flowsheet documentation shows that the recipient was given a Restriction of Rights form, a body search was completed, restraints were properly applied, the individual was properly positioned and in proper clothing, there were no medical contraindications, and the recipient was given the reason for restraint and criteria for its removal (this was completed for all three restraint episodes in this report). Later the same night the recipient requested and was given Lorazepam, 2 mg po at 11:40 pm and Haldol, 5 mg po at 1:15 am.: "Client is agitated, 'I can't sleep, the Ambien is not working. I need medication to help me go to sleep'. Demanding and irritable."

Progress Notes for 1/22/11 show that at 10:30 am the recipient complained of not being able to sleep and a physician was notified to evaluate her. She refused her prescribed medications and requested and received Ativan for sleep. Later the same day (11:40 pm) the Nursing Notes state, "Verbal intervention, limit setting, and med teaching provided. Client is agitated, 'I can't sleep, the Ambien is not working. I need medication to help me go to sleep'. Demanding and irritable. 'I came here for help because I couldn't sleep'. Was loud, and not redirectable. Lorazepam 2 mg given po. Ineffective individual coping, Pt mood disorder with insomnia and agitated behavior. Will monitor effect of prn med and will continue with frequent observation". A short time later (1:15 am) the Nursing Notes indicate the physician was called regarding more escalating behaviors and he ordered Haldol, 5 mg po and Diphenhydramine 25 mg po.

Progress Notes for 1/23/11 at 7:30 pm state the recipient began demanding to see a movie in the dayroom: "She started getting angry because she didn't like the movie, she demanded to write a letter of complaint, given paper. She wants it given to manager, psychiatrist, because her needs to watch a movie she approves were not met ASAP". The recipient's agitation increased until 11:45 pm when she requested and received Haldol 5 mg po and Diphenhydramine 25 mg po. The following day, 11/24/11, at 8:45am, the recipient was given Lorazepam, 2 mg and Haldol 5 mg po: Alert, patient screaming, loud, yelling, threatening staff, calling names, unable to redirect. Stat order given. Patient sitting by the dayoom very irritable but able to redirect." Following this event is a nursing note which states, "…Pt was explained that she can't have meds when she wants and is getting medications for her withdrawals already as scheduled meds…."

Progress Notes for 1/25/11 5:00 pm state, "Client screaming at desk demanding Thorazine. Explained to her Thorazine was not ordered she started screaming, demanding a grievance form and making fun of staff and threatening to get a lawyer. Explained to her her BP is 96/54 low for some meds. She continues to scream at desk. Paper given for her complaints. Client offered Lorazepam 2 mg po she continues to get agitated, because she can't get what she wants. This leads to client stating, 'I can't stand you…, I can't stand you. Your hair looks like a clown and I am going to get you all. She proceeds to verbally abuse RN screaming, 'When I talk to you you better not walk away'. RN went to get Ativan. Client is verbally abusive unable to control anger." By 6:15 pm the same day the recipient had escalated in anger and her attending psychiatrist was called for an evaluation. Notes state, "Constantly talking loud longer than 2 hours- causing severe disruption on the unit. Fellow recipients unable to concentrate watching tv. Fellow recipient would like to jump on her. Loud, verbally abusive, with significant profanities. Verbal altercation with fellow recipient- almost broke into fight- no response to verbal intervention- started pounding fist. Behavior is imminent danger to self. Contingent Haldol/Dyphenhydramine as ordered given. Restraint applied. The record contains a Notice of Restriction of Rights for this event. It indicates the reason for the restraint: "Patient is verbally threatening staff, very agitated, PRN meds not effective, pounding fist on the desk, getting other patients agitated with her behavior." It indicates that the recipient did not want anyone notified of the restraint. The restraint flowsheet indicates that the recipient was placed in restraints at 7:45 pm and was removed at 8:40 pm. with constant monitoring and 15 minute checks.

Progress Notes for 1/26/11 at 11:00 am show that the recipient requested and was given Chlorpromazine 50 mg po. Later, at 2:00 pm Nursing Notes state, "'I need you to get me a towel

and put hand sanitizer on it so I can clean the phone now. You mother fuckers move too slow, I just cursed out that Indian bitch doctor and now I have to curse you out too, bitch.' Pt. behavior very threatening, pt. refuses redirection, pt.'s behavior reported to charge nurse."

Nursing Notes for 1/27/11 at 8:55 am state, "'Get me a towel with some bleach on it so I can wipe the phone off'. Pt was told by this writer that bleach was not allowed to be given to pts. Pt. became verbally abusive, threatening toward this writer. 'I'll fuck you up, bitch, you ugly bitch'. Pt. redirected by social worker. However, pt. started to become verbally abusive toward male patient, …'Fuck you … you stupid son of a bitch'. When the recipient escalated to the point of throwing a chair at the male recipient, she was given an injection of Thorazine, 50 mg. The record contains a Notice of Restriction of Rights for this event. It indicates the reason for this intervention: "Severe agitation and verbal threats". It indicates that the recipient did not want anyone notified of the restriction.

Psychiatry notes from 2/01/11 state, "Pt. became very loud, agitated, and irritable. Demanded to be seen by a psychiatrist. Pt. was interviewed. Reports that she couldn't sleep last night, that her mind is racing, and that she is very edgy and irritable. Pt. demands Xanax or increase dose of Clonazepam, because she says that helps her. Pt was educated about the adverse effects of increased dose of benzodiazepines, the potential for tolerance and dependence. Already Clonazepam has increased to 1 mg yesterday. Pt was suggested to accept Depakote or Lithium to stabilize her hypomanic, irritable mood. Pt. says she has taken both Lithium and depakote in past, and had experienced some adverse effects which she does not remember. Refusing to accept any at this time, however open to accept Depakote only if Seroquel and Clonazepam doesn't help her. Plan: increase Seroquel to 1000 mg po daily". Several days later there is another psychiatry note, on 2/03/11 which states: "Received a call from [state hospital] pharmacy that the max dose for Quetiapine [Seoquel] is 1000 mg per day, so the previous order for Quetiapine 1000 mg per day is discontinued".

Nursing Notes for 2/06/11 at 8:30 am state: "Pt got up very agitated for no apparent reason. Verbally abusive toward staff screaming, 'I'll get you mother fuckers. I'll get you all'. Pt. started screaming that she was going to 'fuck us up' and 'kick our asses' if she gets cold cereal on her tray. Pt. took her regular medications but continued to escalate. When trays arrived on the unit with a cold cereal on her tray Pt. started threatening to throw chairs and her tray at staff… Code green was called, physical hold was employed and Pt was placed in 5 point restraints. While placing pt in restraints she continued screaming 'Hurt me, make a mistake so I can sue you fuckers, I'll take all of you. Pt. continued fighting restraints…." A Notice of Restriction of Rights was included in the record. It indicates the reason for the restraint: "To protect from harming self/others." It indicates the recipient did not want anyone notified of the restraints. The restraint flow sheet indicates that the recipient was placed in restraints at 8:20 am and released at 10:30 am. with constant monitoring and 15 minute checks, except that for this event the recipient refused to have her vitals checked.

Nursing Notes for 2/13/11 state, "'I am going to get a lawsuit from this place one way or another. I don't care it it's the doctor or one of these other fuck up staff members and I'll show you what to do, my ex-husband is a lawyer'. Pt. made above statement to pt. Pt. very manipulative on unit- verbally abusive, asking staff for two clean pillow cases, when in fact pt.

had 2 completely fresh linens for bed in her closet. Pt. refuses redirection from staff, inappropriate behavior reported to charge nurse."

The recipient was discharged on 2/14/11.

Hospital staff were interviewed regarding the complaints. They stated that the recipient was placed in restraints because she was an imminent threat of physical harm to herself or others and they feel that the documentation supports this. While in restraints, staff report that they monitor the recipient continually and recipients are generally allowed out of the restraints, if they are not violent, to use the restroom. If they remain in restraints, they are given a bedpan for toileting upon request. Staff stated that they are very responsive to requests from recipients in restraints and a patient would not be allowed to remain soiled for any length of time.

Hospital staff reported that this recipient demanded medication constantly. Initially (for first 5 days perhaps) the recipient may have been experiencing some withdrawal symptoms, but generally she was seeking different medication or stronger doses of her medication. Staff reported that the recipient was counseled repeatedly about her medications, that the medication had to reach a therapeutic level to show any effectiveness, however she insisted on demanding more or different medications. They stated that the recipient threatened to sue the staff and hospital when she could not have her requested medication, even when she was counseled that it could be harmful. Staff reported that the recipient was only given forced psychotropic medication when she was a threat of harm to herself or others and this occurred one time when she threw a chair at another recipient.

Hospital staff reported that linens and hygiene articles are placed out in a general area for all patients to access two times each day. They stated that patients often take extra towels, etc., however they are available at all times upon request.

STATUTORY BASIS

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent physical harm, the Code outlines specific measures to ensure that it is safe and professionally applied:

"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event

may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section….

(c) The person who orders restraint shall inform the facility director or his designee in writing of the use of restraint within 24 hours.

(d) The facility director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.

(e) Restraint may be employed during all or part of one 24 hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the facility director.

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others…. (405 ILCS 5/2-108)."

The Mental Health Code states that every recipient of services shall be free from abuse and neglect (405 ILCS 5/2-112). Neglect is the failure to provide adequate medical or personal care which results in physical or mental injury or the deterioration of physical or mental condition (405 ILCS 5/1-117.1).

The Mental Health Code guarantees the right to refuse treatment unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services…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).

FACILITY POLICY

Chicago Read provided hospital policy for Use of Restraint and Seclusion (Number 02.02.06.0030). This policy comports with all the directives mandated by the Mental Health and Developmental Disabilities Code as outlined above. The procedures for nursing care for those in restraints must include direct observation of the individual, a summary of his behavior at least every 15 minutes, checks of vital signs every 15 minutes, release of limbs from restraint every hour for 5 minutes, providing for toileting opportunity every 2 hours or upon request, offering fluids every two hours or upon request, and providing food and personal care as needed.

Chicago Read provided hospital policy for Administration of Psychotropic Medication (Number 02.06.02.020). This policy mandates a physician evaluation of the patient prior to prescribing a prescription for psychotropic medication. It also states that the prescribing physician must ascertain and document whether the patient is capable of giving informed consent, and after discussing the prescribed medication with the recipient, a written consent must be obtained. The policy allows for recipients to refuse psychotropic medication and it indicates that a refusal to take this medication is not in itself an emergency. An emergency administration of refused medication is needed to prevent an individual from causing serious and imminent physical harm and other, less restrictive alternative treatment options have failed. The hospital policy for psychotropic medication comports with the directives mandated by the Mental Health and Developmental Disabilities Code.

CONCLUSION

The recipient in this case was placed in restraints three times during her hospitalization. Each restraint episode included the clinical justification for restraint along with all required documentation, and indicated a threat of harm to the recipient or others, after less restrictive measures failed. Additionally, the record does not support that the recipient was left in soiled linens during a restraint episode; the record extensively documents the requests and care of the recipient during these restraints. Additionally, the recipient received one administration of forced medication on 1/27/11 and this event is described in the clinical record as the result of the recipient throwing a chair at her fellow client, and not the result of her complaining. Finally, the complaint alleges that the staff were not responsive to simple requests for bath linens, aspirin, etc. Staff showed that linens are provided twice daily and are available upon request and that the recipient could easily have requested and been given aspirin as well.

The Human Rights Authority does not substantiate the complaint that the facility did not follow Code procedures when it placed a recipient in restraints for no adequate reason and refused to clean her after she urinated on herself. Also, the complaint that the recipient was

administered forced psychotropic medication because she complained is not substantiated, nor is the allegation that staff were unresponsive to simple requests.