FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY- SOUTH SUBURBAN REGION

REPORT 11-040-9015
Tinley Park Mental Health Center

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. The facility did not provide a response to the report.]

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Tinley Park Mental Health Center (Tinley Park). It was alleged that the facility did not follow Mental Health Code requirements in the detention, treatment, communication rights and discharge of a recipient. If substantiated, this would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Tinley Park is a 50- bed, Illinois Department of Human Services (DHS) facility located in Tinley Park, Illinois.

To review these complaints, the HRA conducted a site visit and interviewed the attending Psychiatrist, two Social Workers, the Director of Nursing, and the Quality Manager. Hospital policies were reviewed, and the recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The recipient was not provided with a copy of the petition for involuntary admission, was not allowed to refuse psychotropic medication- she was told she must take oral medication or she would be given an injection, her visitation was restricted without cause and notice, and the recipient was not given a request for discharge form when she requested it.

FINDINGS

The record shows that the recipient was admitted to Tinley Park on 5/26/11 after having been treated at a nearby hospital for 10 days for medical and mental health issues. When she arrived at Tinley, the recipient signed an Application for Voluntary Admission at 8:22 p.m. and the record shows she was given the Rights of Voluntary Admittee form along with the Rights of Individuals Receiving Mental Health Services form and the facility rights packet. The attending

psychiatrist signed the certification that the recipient was provided a copy of the voluntary application.

The record (Progress Notes and Restriction of Rights Notices) shows several instances of emergency medication administered to the recipient:

5/27/11 5:00 a.m. "…Pt. then pulled AT supplies onto floor and started playing scrabble pieces on a puzzle. She had also asked to talk to a doctor, MOD Dr… called and he said he would be up. He then came up when she was sitting at table, playing scrabble pieces. He said 'Let her play' and left. Pt then got up pacing and started going into peers rooms. Pt. also started pulling on exit door. Pt started hitting and kicking staff as we were trying to calm her down. Called MOD third time and received emergency med for Haloperidol 5 mg IM, and Lorazepam 1 mg IM. With staff and security assist pt. was given emergency medicine. Pt. again was kicking and hitting doors. Escorted pt to bedroom and she pulled away to pull and hit doors. Pt. also trying to hit and kick staff. Pt escorted to seclusion/restraint room and as soon as she entered room she started to fight, hitting and kicking. Pt paced in FLR [full leather restraints] for protection of self and others. Restriction of rights for medicine, hold and FLR given…." Physician Orders for restraint, physical hold, and seclusion are included, and a Restriction of Rights Notice was issued for emergency medication, physical hold, restraint and seclusion. The record also contains the 15-minute nursing flowsheet.

1:45 p.m. "Psych note for emergency med. I [Intervention]- Meds for acute psychosis D [Data]- Pt running back and forth, jumped onto counter, swung against screened windows, trying to get out. A [Affect]…- P [Plan]- Haloperidol 5 mg IM, Lorazepam 2 mg IM, to prevent harm." The record contains a Physician Order for emergency medication along with a Restriction of Rights Notice, the restraint flowsheet and debriefing documentation. Another entry describes the use of restraint along with emergency medication for the same event: "Placed on FLR. Patient attempted to jump over counter, grabbing items over the nurses station, anxious, agitated, unable to follow redirection, was escorted to the seclusion room. While in the seclusion room, patient was kicking the window, throwing self against the door and wall, redirected several times, patient continues to throw self against window, walls and floor. A- Placed patient on FLR. Emergency medication of Haloperidol 5mg and Lorazepam 2 mg IM given…." The record contains a Physician Order for restraint and emergency medication along with a Restriction of Rights Notice for this event.

5/27/11 5:00 p.m. "….Client wanted to escape from the unit while the housekeeping was opened the exit door she walked out and redirected back to the unit. In a few minutes she climbed over the counter and took a book from the nurses station. Then she attempted to attack her peer. Dr… notified. Order received to medicate this client. She refused PO medication. Ativan 2 mg IM with Haldol 5 mg IM with Diphenhydramine 50 mg IM given to her. ROR given..." The record contains a Physician Order for physical hold and emergency medication along with a Restriction of Rights Notice for emergency medication and physical hold.

5/28/11 9:15 a.m. "I- Emergency Medication- Haloperidol, 1 mg IM, Lorazepam, 2 mg IM and Diphenhydramine 50 mg IM. D- Pt. reportedly hostile towards peers, grabbing phone out of hands, trying to climb over nurses station counter. She wouldn't follow redirection. Was given

emergency medication." Another entry continues this event at 9:30 a.m.: "RN Note Emergency Medication. Pt refusing to follow directions climbing over nursing desk, grabbing at charts and papers. Refused to stop. Redirected several times instructed to stay in day area, pushing way into nursing station, pushing staff, grabbing phone from peer. A- Encouraged to follow directions, offered PO PRN. Pt refused. Dr…called. IM Haloperidol IM Lorazepam, and IM Diphenhydramine given. ROR given." The record contains a Physician Order for restraint, physical hold and medication for this event, along with a Restriction of Rights Notice.

2:23 p.m.: "I- Unpredictable behavior. D- Pt. began trying to push out door, jumping up and down trying to knock smoke detector off ceiling, reaching for items on desk with sign-in book and trying to strike out at staff. A- Staff redirected pt. to follow visitors' policy at this facility. P- Pt. had to be escorted out of the visitors' room by charge nurse and other mental health techs. Pt. had to be counseled about aggressive behavior towards unit staff and peers on unit."

2:40 p.m. "I- RN Note. Seclusion, unpredictable. D- Pt. in visitor's lounge pulling on door took visitor's pass from visitor refusing to give back. Pushing past door, jumping at sprinkler system and smoke detector. Grabbing at staff's pen and visitor's log book... " Order for Seclusion, Physical Hold, Restriction of Rights Notice, and Nursing flowsheet included in the record for this event.

4:20 p.m. "I- Thorazine 50 mg IM given. D- As she was coming out of the seclusion room she pushed this writer and was combative. She remained paranoid and suspicious. Dr…notified and an order received for Chlorpromazine 50 mg IM given. Pt took it willingly - pt. didn't wanted any po medication . No ROR given since she took the IM willingly."

6:00 p.m. "I-Seclusion. D- Client is combative, trying to leave the unit trying to remove eye glasses from the face of staff, going from room to room. Refused to eat dinner. Disruptive in the milieu. Unable to concentrate. Least restrictive measures failed. Dr… notified. Placed pt. in seclusion, search completed. ROR given. A- Client is a danger to self and others…." A late entry for 6:00 p.m. written at 7:00 p.m. states, "I- Patient's mother come to visit unable to visit. D- Mother was concerned and wanted to visit [recipient]. Her behavior was inappropriate. She wanted to escape and grabbing whatever she sees on her way, push staff and peers. Explained her situation to her mother. Mother wasn't happy she hung up the phone on me. Pt. was uncooperative to check her pulse or respiration." The record contains the Orders for Restraint, Seclusion, Physical Hold, Restriction of Rights documentation and nursing flowsheet for the event which began at 6:00 p.m. and continues through 6:50 p.m.

5/29/11 at 12:30 p.m. "RN Note. I-Irrational Behavior. Met with pt. due to climbing on furniture refused to get down pushing peers going in and out peers rooms, pacing. A- Pt. unpredictable, not able to respond to redirection, not following direction, yelling 'No' when asked to leave visiting lounge. Refused offer of time out and 1:1 with nursing staff. Redirected several times asked to leave lounge. Pt. escorted by staff for safety. Came to nursing station, pushing pushing past desk, grabbing door. Ran around staff, jumped over desk, attempted to grab items. P- Escorted to seclusion - order received. Criteria for release explained to pt. ROR given."

Continued A- "Writer talked to mother with patient calling, attempting to calm pt. Pt. got off phone and went and pushed peers. Pt. redirected several times and then escorted to quiet room and IM prn given without incident. Writer called mother again to explain situation. A man answered phone and identified himself as her father and stated, 'You guys better let the patient out or I will sue you guys.' Pt.'s mother then took the phone and writer explained that due to the pt;'s unsafe behavior visiting today would probably be non-therapeutic. Mother explained that this isn't the pt.'s normal behavior and she could not understand this and that maybe medicines are causing these behaviors. Writer informed mother that pt. only receiving meds to help maintain safety and that the Doc and SW will be in on Tuesday to discuss discharge, but as long as pt. is danger to self and others she may have to be help but Doc and SW could discuss it on Tuesday…"

8:20 pm "I- PRN Medication. This client initially pushed [mental health technician] while she was doing face check of pt.'s. The [recipient] snatched the phone call of another pt. and hung up. The she went into the housekeeping closet trying to take broom. Staff redirected her. She was restless, unable to concentrate, wants to fight with other patients. She was licking the door and rubbing the door in the visiting room. The she attempted push staff again. PRN med chlorpromazine 50 mg IM with Lorazepam 2 mg IM given…." The record contains a Restriction of Rights Notice for this event.

5/31/11 at 3:20 a.m. "I- Prn Medication. D- Pt. unexpectedly at my desk demanding for staff to open the door. When pt, was told door could not be opened, Pt. then jumped on counter and over my desk. Pt. trying to fight staff and was escorted out of nursing station. Pt. then tried to open exit door by my desk. With staff assistance pt. was given prn Chlorpromazine 50 mg with Lorazepam 2 mg IM…" The record contains a Restriction of Rights Notice for this event.

6/3/11 at 2:00 a.m. "Nursing Note. PRN Medication. I- "…chlorpromazine 50 mg IM per client request. D- Client demanding to have staff open door and release her and trying door to the unit in attempt to escape. Client going into the rooms of her peers. Verbal counsel ineffective. Refused po meds when offered. Client preference met because of extreme agitation/ psychosis."

6/05/11 at 11:30 p.m. "Nursing Note. I-Prn medication. Administered Clorpromazine 50 mg IM at 11:30 pm for extreme agitation. D- Client is physically aggressive with peers over the use of the telephone. Verbal counsel ineffective. Client took medication willingly…."

The record contains the recipient's signed and witnessed Request for Discharge which was signed on 6/01/11 (Wednesday) at 10:45 a.m. The recipient was discharged on 6/07/11 (3:15 p.m.).

FACILITY REPRESENTATIVE RESPONSE

Facility representatives were interviewed regarding the complaint. They stated that the recipient signed a voluntary request for admission while still in the Intake Unit of the facility and the attending physician certified that she was given a copy of the application as well as information regarding her right to a voluntary discharge. Staff indicated and the record supports

that the recipient was given a Request for Discharge and then discharged within the legal requirement.

Facility representatives discussed the use of forced emergency medication. They stated that just as the record shows, the staff attempt to address dangerous behaviors beginning with the least restrictive intervention, and thus the notes indicate that staff attempted to counsel the recipient, offer time out in her room, offer oral medication, and perhaps seclusion. When the behaviors escalate to the point that no other alternative is available to maintain the safety of the recipient or others, then medication or restraint may be necessary. Staff indicated that they have worked very hard at improving the documentation of recipient behaviors, especially when it is necessary to show the clinical rationale for emergency measures. The HRA also noted that the clinical documentation was very well done.

The facility staff discussed the incidents when the recipient was denied visitation. They stated that recipients would only be denied visitation if they were in restraints, seclusion, or some dangerous situation occurred which would strongly prohibit visitation. In this case, both instances involved the recipient's behaviors that resulted in seclusion, and thus the recipient was not able to receive visitors. Both of these events were explained to the visitors and Restrictions of Rights were completed for the seclusion, and issued to the recipient, who did not wish for anyone be notified.

STATUTORY RIGHTS

The Mental Health and Developmental Disabilities Code states that any person 16 or older 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." (405 ILCS 5/3-400). Additionally, the Code states, "The written application form shall contain in large, bold-faced type a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission. Upon admission the right to be discharged shall be communicated orally to the recipient and a copy of the application form shall be given to the recipient and to any parent, guardian, relative, attorney, or friend who accompanied the recipient to the facility." (405 ILCS 5/3-401).

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, mandating an individual services plan with a periodic review of the plan and input by the recipient. Also, the recipient's preferences for emergency interventions are to be noted in the plan. If services include the administration of psychotropic medication, the physician must advise the recipient in writing of the side effects, risks and benefits of the treatment as well as alternatives, and must determine and state in writing whether the recipient has the capacity to make reasoned decisions regarding the treatment. If the recipient lacks decisional capacity the treatment may only be administered in case of an emergency or pursuant to a court order (405 ILCS5/2-102 a).

Should the recipient wish to exercise the right to refuse psychotropic medication, the Mental Health Code guarantees this right unless it is necessary to prevent serious and imminent physical harm to himself or others and no less restrictive alternative is available. If the recipient refuses this medication he must be informed of available alternate services and their risks as well as possible consequences of refusing 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, the facility director, and any person or agency the recipient designates, and it must be recorded in the recipient's record (5/2-201).

The Mental Health Code states, "…a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation." These rights may be restricted only in order to protect the recipient or others from harm, harassment or intimidation (405 ILCS 5/2-103).

FACILITY POLICY

Tinley Park Mental Health Center provided facility policy relevant to the complaint. In the *Right to Discharge for Voluntary Patients* (Policy #235), it states that "A copy of the application form must be given to the patient at admission, as well as to any parent, guardian, relative, attorney, or friend who accompanied the patient to Tinley Park Mental Health Center. At the time of admission, the right to request discharge must be orally communicated to each voluntary patient by the Admitting Nurse. Any treatment staff person approached by a patient who is verbally requesting discharge must promptly offer the patient an Illinois Department of Human Services *Request for Discharge* form, assist the patient as necessary in filling out the form, and witness the form."

In the Tinley Park *Consumers' Rights and Responsibilities* packet (Policy #2041), it states: "Consumers have the right to refuse treatment, including medication to the extent permitted by law and to be informed of the medical and legal consequences of such action. If treatment is refused, it shall not be given unless such treatment is necessary to prevent consumers from imminent harm to themselves or others and a less restrictive treatment alternative is unavailable."

The same packet also states the policy for visitation: "Consumers are entitled to receive the visitor's you designate, including, but not limited to, a spouse, a domestic partner, another family member, or friend, send and receive mail ad make and receive phone calls except where it is necessary for the welfare of the consumer or the safety of others to impose restrictions."

CONCLUSION

The clinical record shows that the recipient was admitted as a voluntary recipient in the Intake Department of Tinley Park and given her voluntary admission rights and information. It also shows that she requested and then completed a Request for Discharge form on 6/10/11 and was subsequently discharged within the required timeframe. With regard to the recipient's injections, the record shows that the facility practiced a graduated process of least restrictive measures which might have included the offer of oral medication before the decision was made to proceed with an injection or restraint, and the record supports the staff rationale for these

measures. Also, the record shows that the recipient was in seclusion on the two occasions when her visitation was restricted and that the staff provided the justification for this restriction in the clinical record and to the visitors themselves.

The HRA does not substantiate the complaint that Tinley Park did not follow Mental Health Code requirements in the detention, treatment, communication rights and discharge of a recipient.