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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 13-030-9015
Norwegian American Hospital

Case Summary: The HRA substantiated the complaint that a recipient requested but was denied a copy of his petition for involuntary admission and was given an injection but wasn't told what the medication was or why it was given. The HRA did not substantiate the allegations that the recipient was placed in a quiet room for two hours and then left there for five hours and that he was not given information on filing a grievance.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Norwegian American Hospital (Norwegian). It was alleged that that a recipient requested but was denied a copy of his petition for involuntary admission, was placed in a quiet room for two hours but was then left in there for five hours, was given an injection but wasn't told what the medication was or why it was given, and was not given requested information on filing a grievance. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Centers for Medicare/Medicaid Conditions of Participation for Hospitals (42 C. F. R. 482.13).

Norwegian is a 200-bed, acute care community hospital serving residents of the near northwest Chicago area. The hospital incorporates a 31-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Regulatory Affairs Manager, the Mental Health Liaison, and the Interim Nurse Manager. Relevant hospital policies were reviewed, and records were obtained with the consent of the recipient.

COMPLAINT SUMMARY

The complaint indicates that the recipient requested his petition but was told that he would receive it in 30 days. He was allegedly told he would be placed in a quiet room for 2 hours but then was left there for 5 hours. He was also allegedly given injections but did not know why or what the medications were that he was given, even though staff knew that he had negative reaction to Haldol. When he asked staff how to file a grievance he was ignored and told, "Oh everybody complains."

FINDINGS

The record shows that the recipient was transferred from a hospital emergency department to Norwegian Hospital on a petition for involuntary admission completed on 2/28/13. The recipient's Psychiatric Mental Health Assessment, completed 2/28/13 at admission, is included in the clinical record. It states, "Pt is a 36 y/o male with a history of schizoaffective disorder is admitted after he made 40 phone calls to the police and his social worker stating he was suicidal and was also thinking about killing his landlord. Pt denies making any phone calls. He also denies any suicidal or homicidal ideations. Reports, 'I was in my bed sleeping when the police picked me up and sent me to the emergency room.' He is currently non-compliant with his medication because, 'I run out.' He endorses a history of auditory hallucinations but denies hearing any voices currently. He is unable to elaborate on his symptoms at this time. He denies any psychiatric crisis at this time and therefore refused to sign in voluntarily." Progress Notes from the same day state that, "…Pt refused to sign any forms stating I shouldn't be here. Remains on a petition and certificate. He was given a copy of his petition. Cooperative with interview after firm limits set…" The record does not contain the petition indicating that the petition was given to the recipient within 12 hours.

Progress Notes from 2/28/13 state that the recipient indicated that his medications included Klonopin, Thorazine and Effexor. His inpatient psychotropic medications include Lorazepam, Klonipin, Thorazine, and Tegretol. The record contains a Medication Consent Form which indicates the recipient's signed informed consent for the administration of Ambien, Ativan, Cogentin, Effexor, Haldol, and Tegretol, all consented to on 2/28/13, the date of admission. While hospitalized, the recipient was also prescribed Haldol and Ativan for emergency use.

Progress Notes from 3/01/13 state: "Pt is visible in the milieu. Pt is anxious to see his doctor and medication [sic]. Pt would become upset at doctor for not prescribing him the medication he wants. Pt became verbally aggressive with the doctor. Pt was directed to the quiet room. Pt was provided with positive feedback. Pt is preoccupied with taking certain medications."

Physician notes from 3/02/13 state, "The patient immediately started screaming and was verbally abusive to this evaluator as I walked onto the unit. He was hostile, oppositional, and very agitated. The patient was complaining that his medications had been changed; specifically, the patient was very upset that his Klonipin regimen was decreased. The patient was not responsive to talking down and security had to be called…."

The recipient's first injection of emergency medication is described in Progress Notes from 3/03/13 at 9:45 a.m. "Patient redirected to leave nursing station. Patient refused and became upset. Agitated and he became verbally and physically aggressive and took clock off the wall and slammed it on the floor. Patient agitated and refusing to follow instruction at this time. Patient encouraged to remove himself from environment to decrease his stimulus patient refused. Patient encouraged to go to room and calm down patient refused. Patient given Thorazine 50 IM [intramuscularly] and Ativan 2 mg IM for safety of the unit and other patients on the unit and

staff. Patient unpredictable and destruction of property patient also threatening to harm staff." There is no Restriction of Rights Notice issued for this incident.

The recipient's second injection of emergency medication is described in Progress Notes from 3/04/13 at 12:11 a.m. "Patient was loud and agitated screaming at a staff member. Was instructed to go to his room to destimulate. Pt was compliant but continued to scream out and remained verbally abusive. Medicated with Thorazine 50 mg IM and Ativan 2 mg IM at 8:00 p.m. Was cooperative and asked if he could have his 9 p.m. meds early. Pt medicated as requested and is resting quietly at this time." The record contains a Restriction of Rights Notice for this event. It indicates that the recipient was given forced emergency medication, however the reason is not given. It indicates that the recipient wanted no one notified.

Progress Notes from 3/04/13 at 11:45 p.m. state, "Pt was very angry and threatening staff because he did not receive a portion of his food. Encouraged pt to remain calm while the secretary calls the cafeteria for another tray. Pt refused to follow directions of the staff and was threatening staff. Pt was placed in quiet room and medicated with the assistance of MHCS on duty and security officers. MHC washed /dried pt's clothes and had a 1:1 consultation with him." There is no Restriction of Rights Notice for this event.

On 3/07/13 Physician Progress Notes indicate that the recipient was concerned about his medications: "The patient now says that he has akathisia from all of the prn medications that he has. The patient's symptoms, however, do not appear to be akathisia as he presents with what appears to be dancing movements with his legs. He remains expansive. The patient, however, remains compliant with medications and so far today has been redirectable. The diagnosis remains at bipolar affective disorder. The current plan is to continue to monitor response to medications." On 3/08/13 Physician Notes state, "…The patient was very thankful over being put on Benadryl. He continues to insist that he gets side effects from Haldol, but requested to have his Ativan prn increased. The patient was informed that he would alternate Benadryl and Ativan…."

On 3/08/13 Progress Notes indicate the recipient was restrained and medicated: "Patient got medicated with prn [as needed] MOM 30 ml for constipation at 5:05 p.m., Vit A&D ointment at 6:26 p.m., Nasal spray at 6:30 p.m., Ativan 2 mg orally at 6:40 p.m, Ambien 10 mg at 8:08 p.m. to aid sleep. Patient kept making demands for more medication in spite of all the aforementioned prns and his scheduled medications. Patient became combative and tended to be destructive as he swung at a nurse behind the Computer on wheels and attempted to break the computer work station. Patient got medicated with prn Thorazine 50 mg IM at 9:35 p.m. Patient continued to be combative, got placed in 4-point restraints at 10:00 p.m. Patient got seen by the hospitalist and patient's psychiatrist." The record contains a Restriction of Rights Notice for this event. The reason given states, "Patient was physically and verbally aggressive toward staff. Patient combative, aggressive toward staff attempted to destroy Computer on wheels." The Notice indicates that the recipient wanted no one notified. The restraint flow sheet is included with the restraint documentation and it indicates 15 minute checks of the recipient as well as the offering of food and toileting. The recipient remained in restraints from 10:00 p.m. until 12:00 a.m.

Progress Notes from 3/09/13 at 7:12 a.m. state, "Patient pacing in hall, getting louder, making swinging gestures with large potential for more aggressive behavior presenting danger to others, both staff and peers. Much redirection repeated with little improvement. Patient out in day area with peers- verbally threatening, bizarre (singing, talking to self). Difficult to redirect. Therefore, Benadryl 50 mg given po [orally], per patient request. Nicotine patch 21 mg also given for nicotine craving. Patient out of quiet room. Again escalating in volume and threats. Bizarre behavior. Again not responding significantly to redirection or prn medication so far. Thorazine 50 mg IM given in left deltoid with patient's agreement. Patient again pacing, angry, grandiose, and not responding to redirection. Swinging arms near peers. Ativan 2 mg IM and Haldol 5 mg given IM in right deltoid and asked to stay in quiet room until calmer, quieter. Patient in quiet room. But still pacing, angry, manipulative re coming out of quiet room. Will continue to monitor and endorse to am shift."

A Progress Note entered at midnight on 3/09/13 states, "Came out of report 3/08/13 11:30 p.m. with endorsed patient in 4-point restraints from pm shift. Patient observed for 30 more minutes then released from restraints since was sleeping soundly without further incident. Attempted to wake patient to contract for safety - but patient very drowsy and unable to respond meaningfully. He did mumble 'yes' to safety query. Patient left in quiet room to continue resting, to further assess behavior and safety before allowing him to return to room with roommate."

Progress Notes indicate on 3/09/13 at 7:12 a.m., "Patient awake and at nursing station with a number of complaints…."Meds teaching session held succinctly; understood by patient, who continued to voice above complaints and requests for prn meds. He became adamant, based on his patient rights. Thus, Ativan 2 mg po, Thorazine 50 mg po and Trammodol 100 mg po given prn. as ordered. Patient returned to his bed and is resting comfortable at this time." The Precaution Documentation record indicates that the recipient was in the quiet room from 9:15 p.m. on 3/08 until 5:45 p.m. on 3/09.

Progress Notes from 3/11/13 at 5:41 a.m. state, "Patient became verbally abusive, pushing doors on unit loudly with tense body posture and intense affect; began swinging arms potentially aggressive to staff and peers. Benadryl 50 mg IM given in right gluteal area to help previous meds take effect and be calmer. Quieter behavior…." There is no Restriction of Rights Notice issued for this event.

Progress Notes from 3/13/13 at 9:00 p.m. state, 'Pt has been visible in the milieu. His mood is irritable and his affect is directed towards staff. The pt.'s mood vacillated quickly between aggressive and cooperative. Pt. required constant redirection for threatening statements and for acting out. Pt was responsible for defecating on the floor of the quiet room. Pt was often argumentative and challenging when redirected." The Precaution Document Record shows that the recipient was in the quiet room from 9:30 a.m. until 3:30 p.m.

Progress Notes from 3/15/13 at 7:29 a.m. state, "Pt became agitated when told that he cannot get nicotine patch at 5:00 a.m. Pt demanded for it. Jump over the nurses station counter and threatening to harm the writer. RN security called and told patient will give him prn. Prn

Ativan and Thorazine was offered and accepted. Will continue to monitor for safety." There is no Restriction of Rights Notice for this event.

The record does not indicate that the recipient requested information on filing a complaint, however the complaint itself is part of the clinical record

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed about the complaint. Staff persons were present who had received the recipient's petition for involuntary admission and they were able to strongly confirm that he received a copy of the petition during his admission process. They also indicated that it was entered into the notes that he had received it. Staff indicated that the petition itself was not included in the electronic file since it was generated at another hospital.

Hospital staff addressed the issue of the prolonged quiet room stays. They stated that the facility has not utilized seclusion for several years, however they do maintain a quiet room that is never locked and is always available to patients who may want to be alone. The quiet room is also utilized for restraint episodes. The room has a bathroom and a bed. The recipient in this case utilized the quiet room almost as a private room and came and went frequently. When he was placed in restraints on the 8th, the recipient was in the quiet room but after a period of time (as reflected in the notes), his restraints were removed and he was allowed to remain in the room because he was sleeping soundly and staff did not want to disturb him to make him return to his room.

Hospital staff were interviewed about the emergency mediation given to the recipient and asked whether he was informed what medication he was receiving and why. They stated that even in emergency situations, when staff approach a recipient for an injection they inform recipients what they are receiving, for instance the staff say, "The doctor has ordered…for you…" before the person is injected. This is standard practice and staff members did not think that the recipient would not be aware of his medication, even in an emergency (they indicated that the recipient signed an informed consent for his emergency medications). Staff were also asked about the use of Haldol after the recipient complained of akathisia. Staff indicated that all nurses and physicians are aware of and watch for symptoms of akathisia and they did not observe these symptoms in the recipient. Also, staff indicated that the recipient did not rescind his consent for Haldol. Staff were asked about the recipient's preferences for emergency treatment form and they said that although this type of question may be included in the nursing assessment, they do not have a separate form for this. The staff also confirmed that the record does not include a physician statement of decisional capacity.

Staff were interviewed about the recipient's grievance. They indicated that there is hospital policy in which all staff are trained for handling complaints and recipients are given information on filing complaints at admission- the recipient followed these procedures for requesting writing materials and presenting the complaint to the appropriate staff. The recipient then submitted the complaint on 3/04/13, but when staff read it they thought it was more of an explanation of his behavior on 3/03/13 and why his behavior led to emergency medication than it was a complaint. Nevertheless the complaint was reviewed by staff. The procedure generally

initiates with the staff on duty and the hope is that the complaint can be resolved "bedside" or at the level of unit staff. If not, then the complaint progresses to the Charge Nurse, who also attempts to resolve it before turning it over to the unit manager, who will meet with the patient. The procedure is patient driven, so at any time the recipient can reject the solution and the complaint will then progress to the next level. In this case the complaint was not forwarded to the Nurse Manager, so staff feel that the resolution offered by the Charge Nurse was accepted by the recipient.

STATUTORY BASIS

The Mental Code mandates that within 12 hours after admission, the recipient must be given a copy of the petition for involuntary admission (5/3-609). Also the Code states, "Every mental health facility shall maintain adequate records which shall include the Section of this Chapter under which the recipient was admitted, any subsequent change in the recipient's status, and requisite documentation for such admission and status (5/3-202)."

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 including the reason 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).

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 defines Seclusion as "the sequestration by placement of a recipient alone in a room which he has not means of leaving" (405 ILCS 5/1-126). It may be used only as a therapeutic tool to prevent a recipient from causing physical harm to himself or others. Seclusion requires a written order of a physician, clinical psychologist, clinical social worker, or registered nurse (405 ILCS 5/2-109). A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization by a physician or those named above (405 ILCS 5/2-108 i).

Under the CMS Conditions, "A hospital must protect and promote each patient's rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care…. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion." (42 C.F.R. 482.13).

HOSPITAL POLICY

Norwegian provided the hospital policy related to Involuntary Admission (#BM3.005). Although the recipient in this case was given his petition within the statutory timeframe, the policy does not include a directive to staff to do so.

Norwegian provided hospital policy for restraint and seclusion. Restraint is defined as any method of restricting an individual's freedom of movement, physical activity, or normal access to the body. Seclusion is defined as the involuntary confinement to a room or area where the patient is physically prevented from leaving the room as well as when the patient is restricted to a room and staff intervenes to prevent them from leaving it. The hospital policy comports with all Mental Health Code requirements for restraint and seclusion.

Norwegian provided the hospital policy and procedure for Patient Rights and Responsibilities (#BM3.050). It states, "It is the policy of NAH that patients receive considerate and respectful care at all times and under all circumstances with recognition of personal dignity in a humane environment that affords appropriate privacy and reasonable protection from harm. Patients have a right to receive prompt and appropriate treatment for any physical or mental disability. Patients have the right to the least restrictive conditions necessary to achieve treatment purposes. No patient, except as otherwise provided by the applicable state law, shall be denied legal rights solely by virtue of being voluntarily admitted or involuntarily committed. These rights include voting, making wills, entering into contracts and other rights held by any citizen." The hospital policy also states, "Patients have the right to be free from unnecessary or excessive medication. Patients requiring emergency medication for control of behavior deemed dangerous to themselves or others should be evaluated by a physician prior to ordering such medications, but if this is impractical, a written order may be entered on the basis of telephonic authority received from a physician. Medications shall not be used as a punishment; for the convenience of staff, or in quantities which interfere with the patient's treatment plan." Additionally, the policy states that if a valid and sufficient reason exists to restrict a patient's rights, "the patient must be promptly notified of any restriction and the reason for imposing the restriction."

Norwegian provided hospital policy and procedure on Patient Complaints/Grievances (#RI 2.05). A Complaint is defined as a single issue that is simple in nature and can be easily handled by the patient and staff upon receiving the complaint- this does not require documentation. A grievance is a written or verbal complaint about patient care that is not resolved at the time of the complaint by the staff who are present. The staff member receiving the complaint will determine the nature and complexity of the complaint and will address the issue if he/she is capable of making an immediate resolution. Beyond this staff person, the grievance is then forwarded to the Director or appropriate administrator, who contacts the complainant to obtain further information and determines the complainant's desired outcome. If the Director deems it necessary he/she will conduct an investigation and notify the Risk Manager. If a resolution is not possible after these steps, the Manager of the Patient Experience is consulted for assistance. The Manager of the Patient Experience is responsible for contacting the complainant and act on their behalf to resolve the concerns. An ad-hoc advisory committee to assist with the resolution may be convened as necessary. At the conclusion of the investigation the patient will be provided a written response from the Manager of the patient Experience or a response written by the Manager on behalf of the designated director indicating the steps taken to address the grievance and the results of the review. If the complainant is not satisfied with the outcome of the review the complaint will be taken to the Hospital Chief Executive Officer or designee who will complete the investigation and issue the results to the

complainant. The review and resolution of complaints and grievances must be conducted within 30 days unless there are extenuating circumstances and an extension is agreed to by the complainant.

CONCLUSION

The record states that the recipient was given a copy of his petition and this is confirmed by the staff who gave it to him at admission, however the petition itself is not included in the clinical record, which is mandated by the Mental Health Code, both upon admission, and whenever the status of the recipient changes. The HRA substantiates the complaint that the recipient was not given a copy of his petition within the statutorily mandated timeframe.

The complaint in this case suggested that the quiet room is a locked room used primarily as a means for controlling recipients' escalating behaviors (similar to seclusion). Staff however, indicate that the quiet room is open for recipients to use as they wish- it is never locked, and recipients are free to leave it at will (unless they are restrained there). Although the recipient was in the quiet room for a prolonged period on 3/08/13, documentation shows that the recipient's restraints were removed, and staff attempted to wake him but could not. The recipient remained in the room not because he was being "left there" or restrained. There is no evidence that the recipient's rights were being restricted at this time, however the HRA cautions facility staff that recipients' rights are being restricted when the room is used for restraint, so it is not simply a "quiet room" when used as such. The HRA does not substantiate the complaint that the recipient was placed in the quiet room for 2 hours and then left there for five hours.

The complaint indicates that the recipient was given an injection but wasn't told what it was or why he was given it. Hospital staff indicate that recipients are informed, even in emergencies, what medication they are being given and for what reason. Although the recipient signed informed consents regarding emergency medication, it is not clear that he was aware of the medications he was receiving during these incidents. Injections given on 3/02/13, 3/04/13, and 3/11/13 are all missing Restriction of Rights Notices, required by the Mental Health Code for the very reason that recipients are to be informed about the way in which their rights will be restricted and why. The Restriction of Rights Notice issued on 3/03/13 does not contain a reason for the restriction and is not completed. Additionally, the record is missing the crucial components mandated by the Code for the administration of psychotropic medication, namely, a physician statement of decisional capacity, informed consent for psychotropic medication (there is no informed consent for Thorazine or Klonopin), and preferences for emergency treatment, which are to be noted on treatment plans. Finally, the Mental Health Code ensures the "least restricted environment" by allowing recipients to make decisions regarding their treatment and providers are to consider their views. In this case a recipient was concerned about the effects of Haldol on his physical movements and reported this concern to his physician. Nevertheless, he was administered Haldol again in an emergency situation. The HRA substantiates the complaint that the recipient was given an injection but wasn't told what it was or why he was given it.

The hospital provided their policy for the handling of grievances, which complies with CMS mandates. The progress notes for this recipient do not mention that he submitted a

complaint however the written complaint is contained in the record which indicates that it was given to the appropriate staff. Staff indicated that every effort is made to address complaints "bedside", meaning that they are handled by the staff that are present and are involved at the time of the event. Since this complaint did not progress to the next level, it was assumed that the recipient was satisfied with the results of his initial complaint. The HRA cannot substantiate that the recipient was not given requested information on filing a grievance.

RECOMMENDATION

1. Ensure that the recipient receives a copy of the petition within 12 hours after admission and that the petition is part of all records, regardless of where it originates, as it serves as the hospital's authority to detain the recipient and starts the involuntary process and must be part of the record as mandated by the Mental Health Code.

2. Review hospital policy and Mental Health Code mandates regarding the administration of psychotropic medication, both regularly scheduled and emergency medications. Ensure that recipients give informed consent for all psychotropic medications and that the record contains a physician statement of the recipient's decisional capacity.

3. If a recipient refuses medication, ensure that this medication is given only if the recipient presents an imminent threat of physical harm and no less restrictive measure is available.

4. Include the recipient's preferences for emergency medication in the recipient's treatment plan and ensure that these recommendations are available to staff should the need arise.

5. Always complete a Restriction of Rights Notice whenever a recipient's rights are restricted.

SUGGESTION

1. The Mental Health Code states that "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." Although the HRA cannot challenge the medical decisions made by physicians, we advocate for the acknowledgement of the recipients' concerns regarding the effect of medications on their own bodies (as a medical doctor would consider a medical patient's report of physical symptoms) and hope that physicians and staff honor these concerns by adjusting medications when they can to accommodate the recipients. If a clinical decision is made to override a patient's concerns, then a clinical rationale should be offered to the recipient and placed in the record.

2. When a recipient states that he wishes to file a complaint, document this in the record and indicate what steps were taken to rectify the situation.