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HUMAN RIGHTS AUTHORITY – EGYPTIAN REGION
REPORT OF FINDINGS

Chester Mental Health Center
Case # 13-110-9006

INTRODUCTION

The Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations of rights violations at Chester Mental Health Center:

1. **A recipient was inappropriately administered forced emergency medication.**
2. **A recipient was subjected to inhumane treatment, including staff verbally harassing a recipient and violating a recipient's privacy.**

If found substantiated, the complaints would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and Center policy.

Chester Mental Health Center is a state-operated mental health facility located in Chester, Illinois. It is the most restrictive and secure mental health center in the state and provides beds for approximately 300 male recipients.

The complaint alleges that a recipient was forced-medicated over his objection and without meeting the requirements for emergency medication. The medication was administered after a phone conversation with HRA staff. The complaint also alleges that a facility staff person verbally harasses a patient and violates his privacy by opening the shower door while he is showering. In addition, the allegation states that a staff person does not allow recipients to sit down for a rest break after an activity in the Center's gym.

The HRA investigated the above complaints by communicating with a recipient and the chair of the Center's internal human rights committee. The HRA also reviewed relevant facility policies and the recipient's record, with his written consent.

FINDINGS

The HRA reviewed an email exchange between HRA staff and the chair of the Center's internal human rights committee, dated 8/13/2012 in which the HRA staff person questioned the administration of medication over a recipient's objection. The recipient had contacted the HRA

staff person indicating that he was being threatened with forced medication for not eating and for refusing prescribed medication. The HRA staff had asked the recipient if he had been aggressive toward staff or peers and he reportedly had not been aggressive. He later called back and stated that facility staff had administered the medication by injection. The internal human rights committee chair reported that the recipient had been progressively losing weight and was not eating because he thought that the food was poisoned. The patient's physician felt that the patient was in danger due to poor nutritional choices and the facility acknowledged using forced medication because of concern for the patient's weight loss. The facility staff stated that emergency forced medication was administered without incident after the patient refused oral medication. According to follow-up e-mail correspondence to the HRA dated 08-15-12, the situation was reviewed and it was discovered that the patient did not qualify for emergency enforced medications and the practice was discontinued for the recipient. The facility indicated that court-enforced medication would be pursued.

Regarding the complaint that a staff member tells patients to stand after gym activities and opens shower doors, the internal human rights committee chair reported that there was one incident in which a recipient was told not to sit on the stage located in the gym but that patients are otherwise allowed to take breaks and sit on the gym floor. The Illinois Department of Human Services, Office of Inspector General, was notified about the complaints concerning verbal harassment and a staff person invading a recipient's privacy by opening the shower door.

RECORDS REVIEW

The HRA received a release to examine a recipient's records, including incident reports, restriction of rights notices, medication administration records, physician orders, progress notes and treatment plans.

The recipient was admitted on 5/18/2011 having been found unfit to stand trial. It is stated in treatment plan records that the patient, as of 6/07/2011, was suspicious, guarded, and evasive. Throughout his Treatment Plan Reviews it is stated that the patient entered into angry arguments and often shared irrelevant information. On 5/07/2012, the individual still had symptoms of psychosis but was more cooperative. Facility personnel and treatment plan notes affirm that there was progress and that soon the patient would be considered fit to stand trial. On 6/05/2012, the patient gave correct answers to legal fitness questions, had no thoughts or plans to harm himself or others, and was willing to cooperate with his attorney.

In a psychiatric evaluation completed on 7/02/2012, the patient was described as suspicious and irritable with complaints about his diet. The recipient attended a special treatment plan review on 8/13/2012, at which staff reported that he refused to eat and had lost approximately 50 lbs. since 2011.

On 8/10/2012, the recipient was seen by a dentist for a tooth extraction. The recipient would rate tooth extraction site pain at several levels starting at a rating of 10 on 8/10/2012 at 2:00 p.m. At 2:30 p.m. the recipient rated the pain level at a 6 but he consumed 100% of lunch. At 3:00 p.m. the recipient rated tooth pain at a 5. Staff encouraged him to ask for medication when needed. The recipient then rated the tooth extraction pain at a 4 and medication was given.

On 8/11/12 at 7:15 a.m. medication was given for the pain rated at an 8. At 8:30 a.m. medication was recorded as effective since the recipient had rated the pain at 0 out of 10. The next day, the recipient kept on refusing pain medication. On 8/13/12, it is recorded that the physician's order indicated that staff were to administer psychotropic medication if the recipient refuses. The recipient refused medication and staff documented that the recipient looked "very thin" and of "poor muscle mass."

Progress notes of 8/13/12 stated the recipient was informed by the treatment team that he was being placed on emergency enforced medication by the doctor and he was described as being "uncooperative and argumentative when medication was offered by nurse." Despite staff requests to be cooperative the recipient was not medication compliant. In the presence of the Unit Director, Unit Manager, and a charge aide the emergency forced medication was administered on 8/13/2012. Psychiatry notes document the recipient's refusal, including the recipient's statements that: "They give me rotten food. They don't treat me like a human being." The assessment concluded that the recipient was highly paranoid due to mental and physical health deterioration. The facility staff had confirmed that emergency forced medication was administered to the patient. The staff personnel stated that the patient had been progressively losing weight. It was also stated that the patient had refused to be weighed or to have vitals taken. The Chester staff physician felt that the patient was a danger to himself due to poor nutritional choices which was the reason that emergency forced medication was administered. A 08-13-12 information report regarding the emergency medication administration stated that the incident did not involve property damage, physical intervention, restraint or injuries; instead, the information stated that the recipient:

> "…was extremely uncooperative and argumentative with staff when offered his emergency enforced medication. The Rec was on the phone calling in complaints on staff, demanding to know the names of everyone present. The Rec had to be asked numerous times to comply, but he would not. Only after the arrival of the Unit Director, Unit Manager and Charge Aide were the meds able to be given via injection….[The recipient] remains agitated and continues to threaten to have staff members fired."

The restriction of rights notice stated the following with regard to the reason for the restriction: "…pt cont. to refuse po [by mouth] Olanzapine, pt. delusional, doesn't want to eat. Emergency enforced Olanzapine IM given." Another restriction of rights notice, dated 08-14-12 at 8:15 a.m. indicated that the recipient was administered emergency medication again "Due to physical and mental declining. Refuses to eat majority of time d/t delusions." The physician progress notes indicated that the emergency medication order was for 24 hours. The recipient's treatment plan includes goals for medication refusal such as medication education and counseling.

The HRA reviewed no documentation in progress notes or in the treatment plan about recipient complaints concerning staff verbally harassing him or opening the door while he showers.

Policy Review

The HRA reviewed the Chester Mental Health Patient's Rights policy. According to the policy, patients have the right to refuse medication. As stated in the facility's Refusal of Psychotropic Mediation policy, in the event that "a patient refuses medication a physician must determine if the patient meets the criteria for emergency medication and/or enforce involuntary medication and document the determination in the clinical record." It is also stated in another Chester policy, titled Medication Compliance, that "patients have the right to refuse medication under the Mental Health and Developmental Disabilities Code unless they are in imminent physical danger to themselves or others." The policy states that the "nurse who administers medication should always encourage medication compliance and should explore with patients any reasons for their reluctance to take medication"

The Chester Mental Health Center's Code of Conduct policy states that the "facility has zero tolerance for intimidating and disruptive employee misconduct. The behaviors include but are not limited to verbal and physical conduct, threats, improper use of language, aggression, an insubordination." In relation to the reporting process of employee misconduct, all Department of Human Services' employees are required to report incidents of Code of Conduct violations. Employees must complete written statements regarding alleged incidents and the supervisor will forward the report for the Hospital Administrator. Failure to report a Code of Conduct violation incident can result in disciplinary action.

Supervisors, in responding to a complaint involving the Code of Conduct, will take necessary steps by evaluating the nature of the incident and preventing further breaches of the Code of Conduct. It is stated in the policy that "progressive disciplinary action will be faced with consequences against those individuals found guilty of failure to follow the facility's Code of Conduct."

The HRA reviewed a Chester policy titled, Reporting and Resolving Complaints or Concerning Patients, which states that "patients, families, significant others and other interested parties have open recourse and opportunity to identify and resolve concerns and complaints concerning treatment, other services, or conditions at Chester Mental Health Center." Since the complaint fell under the area of recipient physical, sexual or mental abuse or neglect the procedure requires that the complaint be sent to Hospital Administrator or Facility Office of Inspector General (OIG) liaison.

MANDATES

Regarding the recipient's refusal of medication, the Mental Health Code states: "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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" (405 ILCS 5/2-107).

Regarding the alleged verbal harassment and invasion of privacy, the Mental Health Code states that individuals have the right to humane care and "Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-102 and 2-112).

CONCLUSION

Complaint #1: A recipient was inappropriately administered forced emergency medication.

The complaint states that the mental health center violated the recipient's right to refuse medication when he was forced medication. As indicated in the records, the recipient exercised his right to refuse medication under 405 ILCS 5/2-107 on 8/1/12. It was reported on a Nursing Reassessment Summary that covered dates 7/28/12-8/24/12 that the recipient refused medication. On 8/13/12 it is recorded in another Nursing Reassessment Summary that the recipient once again had refused medication. The facility did not comply with the recipient's right to refuse medication, or with the Code requirement that emergency medication can only be given to prevent "…serious and imminent physical harm to the recipient or others." Due to the fact that the facility employees had admitted that medication was forced because of concern over the patient's weight and not due to serious and imminent physical harm to the recipient or others, the HRA finds this complaint to be **substantiated**. The HRA submits the following **recommendation**:

- The HRA recommends reviewing and following the Mental Health and Developmental Disabilities Code and facility's policies on medication compliance, right to refuse medication, treatment plan reviews of medication, and emergency medication protocol. The HRA recommends retraining all staff, including physicians and unit staff, on these topics. Based on the documentation it appeared that unit administrative staff, direct care staff and the ordering physician were involved in the incident. The HRA requests documentation of the staff training.

The HRA also offers the following suggestions:

- If the facility believes a recipient needs medication due to weight loss or other physical or mental concern, consider the pursuit of a court order.
- The HRA was concerned that the recipient had dental needs that may have impacted his eating habits and weight loss. In fact, he had a dental extraction within 3 days of the enforced medication. The HRA strongly suggests that the facility review all aspects of a recipient's needs when considering treatment protocol, including forced or court-ordered medication.

Complaint #2: A recipient was subjected to inhumane treatment, including staff verbally harassing a recipient and violating a recipient's privacy.

The complaint alleges that a Chester staff member verbally harasses patients and violates patients' privacy by opening the shower door while patients are showering. Due to the fact that

the HRA found no evidence to support the allegations, the complaint is **unsubstantiated**, but offers the following **suggestions**:

- The HRA suggests for all staff to review and follow the Code of Conduct policy as well as the policy on Reporting and Resolving Complaint or Concerns Involving Patients.
- Ensure that patients' rights to humane care and privacy are respected by all staff.
- Consider quality assurance measures to address staff to recipient interactions and recipient privacy.