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Egyptian Regional Human Rights Authority
Report of Findings
13-110-9012
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

1. Recipient's pain medication was changed to a less effective medication and given less frequently; recipient feels this is due to retribution for another incident. Recipient was required to have a urinalysis but did not get results, then was placed on an antibiotic for a month but doesn't know what for.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Illinois Administrative Code (Adm. Code) (59 Ill. Adm. Code 110.30).

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan… "

The Illinois Administrative Code (59 IL ADC 112.30) in section (d)(1) states "For the purposes of this Section, the person(s) authorized to give consent shall be informed of the treatment plan for medical and dental services, and shall be provided with the information necessary to give informed consent. The documented agreement to the individualized services plan will obviate the need for specific agreement to the treatment plan for medical and dental services." Section (e) Communicating examination findings states
"Significant or negative examination findings obtained from the recipient's physical examination results of laboratory tests as they become known shall be communicated to the recipient or, if the recipient is under guardianship, to the recipient's guardian, or, if the recipient is a minor to the recipient's parent or guardian. The fact that such findings were communicated to the recipient, parent or guardian shall be documented in the recipient's clinical record. "

Investigation Information for the Allegation:

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and reviewed facility policies. With the recipient's written authorization, copies of relevant information from his clinical chart were reviewed by the Authority. Finally, the OIG report relating to an allegation of neglect was reviewed. The specific allegation was that pain medication ordered by a doctor following a tooth extraction was not given.

I. Recipient Interview:

The recipient informed the Team that he had been receiving Ibuprofen for his back pain which was changed to Tylenol and was only given 2 tablets every 8 hours instead of every 4 hours. He also stated that following a tooth extraction, he was not given the pain medication that the dentist prescribed him. He said he was written up for throwing a medication cup prior to this medication change, but denies doing so. He feels like the medication change was done as retribution for the alleged incident of him throwing a medication cup. The recipient also told the Team that a urinalysis was completed and he was then given an antibiotic to take for a month but was not informed of why.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs):

The Team reviewed the TPR from November 28, 2012. It is noted in the TPR that the recipient has "participated sporadically in gym and yard sessions this report, a slight decrease". One of the problems listed in this TPR to address is "to decrease and/or alleviate pain and discomfort." The current medication for treatment intervention listed is Acetaminophen 650 mg PRN every 8 hours for pain. It notes that the recipient has had numerous complaints of pain this assessment. The treatment intervention indicates that nursing staff will inform physician if pain is not relieved, for further evaluation and notes that during this reporting period no physician notification was required.

B. Medical Records:

On 5/17/12 there were orders written for Acetaminophen/Hydrocodone 500/5 for pain as well as Methocarbamol for muscle relaxation which states "when available" beside it and also for Acetaminophen 650 mg PRN for pain. The Nursing Reassessment Summary dated 5/17/12-5/24/12 notes that the Acetaminophen/Hydrocodone 500/5 was for 17 days due to rotator cuff surgery on 5/1/12.

Medication Administration Records (MAR) from June 2012 has Acetaminophen 650 mg listed as a PRN but no initials to indicate it was given throughout the month of June. Acetaminophen/Hydrocodone 500/5 daily is also listed. The initials indicate it was given daily at 8:00 am, 3:00 pm and 9:00 pm from June 1st through 15th. The order was changed to BID and the medication was given at 9:00 am and 9:00 pm June 16th through 24th. Then, it was changed again and given at 9:00 am only June 25th through 30th. Also listed on the June 2012

MAR sheet is Ibuprofen 600 mg daily and initials indicate it was given daily at 7:00 am and 9:00 pm June 1st through 30th. Cyclobenzaprine (muscle relaxer) was also on the MAR sheet and initials indicate it was given daily at 9:00 pm from June 1st through 30th.

On 10/26/12 the dentist ordered Vicodin 5/500 every 6 hours PRN for 4 days due to severe dental pain as a result of a tooth extraction and dry socket resulting from that procedure.

The MAR sheet for October, 2012 lists Acetaminophen 650 mg PRN and initials indicate it was given 5 times from October 11th through 19th and again on the 25th. The Acetaminophen was discontinued on 10/31/12. Ibuprofen 600 mg PRN was also listed and signatures indicate it was given 5 times from October 1st through 14th and was discontinued on the 15th. On October 16th at 10:15 pm a one time order came from the doctor to give 600 mg Ibuprofen for tooth pain. The Team did not find Vicodin listed on the MAR.

The Nursing Reassessment Summary dated 10/29/12-11/23/12 states that "treatment from Epididymitis (Ciprofloxacin 250 mg bid) was no actioned on 11/16/12. Pt was scheduled for Ultrasound of testes on 11/21/12, but pt refused to go to appointment even w/counseling and teaching." The Assistant Director of Nurses informed the Team that the term "no actioned" indicates that the patient completed the course of the antibiotic and no further treatment was ordered.

The Nursing Reassessment Summary dated 11/23/12-12/19/12 states that the recipient utilized Tylenol on numerous occasions for numerous complaints and the physician started him on Ibuprofen 800 mg BID and Duloxetine 60 mg for chronic pain.

C...Progress Notes:

Nursing notes dated from 9/12/12 to 10/15/12 show that the recipient utilized Acetaminophen or Tylenol 7 times and Ibuprofen 11 times. Each time the PRN's were given, the notes document before and after pain levels as reported by the recipient and each time it is indicated that the PRN was effective with the exception of 9/21/12. On this date, there is a note at 9:30 a.m. which said "pt states Tylenol is not helping and wants to see [Dr. name] [Dr. name] notified and states she will be down to see pt." At 1:45 p.m. that same day, the recipient was brought back from the dining room in "extreme pain" to the groin area. Motrin 600 mg was given and the patient was informed when he needs to urinate to let staff know for a urinalysis. The doctor was paged and a urinalysis was obtained and sent to the lab. At 2:35 p.m. the medical director was notified of the results and instructed the nurse to continue pain management and notify if symptoms worsen. The recipient stated he felt better. There was no indication that the recipient was ever refused medication when requested for pain or that he ever complained again that the PRN was not effective.

On 10/18/12 at 9:00 am, there was a medical note indicating that the recipient complained again that his groin hurt. After examination, the doctor ordered a "CBC and UA / ASAP" and ordered "Ciprofloxin x 30 days". At 10:15 am a nursing note indicates a urinalysis was obtained and Cipro 250 mg was started as ordered for epididymitis.

A therapist note dated 10/3/12 states that the therapist asked nursing to make a referral to the medical doctor because of all the PRNs he has had due to body aches (11 times this reporting period).

A nurse's note dated 10/15/12 states that the recipient was at the nurse's cage to take noon medications; the medicine cup and water were sat down. The recipient put the pills in his mouth then threw the medicine cup in the nurse's cage, refused to drink water in front of him and got a drink from the water fountain. The therapist and unit director were made aware of this behavior and a BDR (behavioral data report) was written.

Nurse's notes dated 10/16/12 to 10/30/12 show that the recipient utilized Acetaminophen or Tylenol 12 times and Ibuprofen 1 time. The recipient reported that the PRNs were effective each time. APAP/Hydrocodone or Vicodin was also utilized 7 times from 10/26/12 to 10/29/12 following his tooth extraction. There was a note on 10/25/12 that the medical director was notified that the recipient reported jaw discomfort from the tooth extraction. The medical director ordered Acetaminophen every 6 hours instead of every 8 hours PRN. The Team found no notes regarding Ibuprofen being discontinued on 10/15/12 or the Tylenol/Acetaminophen being discontinued on 10/31/12 as was indicated on the October, 2012 MAR and no indication in the nursing notes that the recipient was informed that his pain medication had been discontinued or changed or why it had been discontinued. The Team did note, however, that there was only one instance of Ibuprofen being utilized on 10/16/12 under a 1 time order from the medical director and that Acetaminophen/Tylenol was utilized 12 times after the Ibuprofen had been discontinued.

III. OIG Report

The team reviewed an Illinois Department of Human Services, Office of Inspector General (OIG) report that was conducted regarding an allegation of neglect of this same recipient. The specific allegation was that following a tooth extraction, the recipient was prescribed a pain medication and that a nurse failed to provide the medication when requested by the recipient. The OIG found this allegation unsubstantiated with recommendations.

Some specific details that were referenced in the OIG report that are relevant to the HRA investigation are as follows:

On November 27, 2012 a staff information report was completed by an LPN documenting that on October 24, 2012 a RN spoke with the dentist and the pain medication for the recipient was discontinued at the request of his doctor. This LPN clarified that the doctor had requested that this recipient not be placed on Ibuprofen due to a kidney problem. The RN clarified that on October 24, 2012, she told the Dental Hygienist that the doctor ordered that the recipient not be placed on Ibuprofen and the order was discontinued and placed in the shred box due to it being written on the carbon copy side of the order not the original side. Since the recipient already had a contingency medication (PRN) for acetaminophen for pain, no further action was needed from the dentist.

The doctor told the OIG that the recipient was admitted to Chester on a pain prescription for Vicodin. He was gradually removed from that and placed on Ibuprofen. The recipient started showing signs of abnormal renal function and the ibuprofen was determined to be the cause, due to its continual use as a pain medication. The recipient was then switched to Acetaminophen as a PRN for pain. The doctor also stated that the recipient was told about each medication change as it occurred and he was fully aware of each change. The dentist was not aware that the doctor didn't want the recipient taking Ibuprofen and the order was discontinued before being administered. The Acetaminophen was utilized for pain following his tooth extraction and the doctor changed the pain medication when she saw that the PRN was not adequately controlling the pain.

The OIG made recommendations to address the issues of: a doctor's order being shredded after it was documented in the progress notes as being written; the lack of any entry into recipient's progress note with regards to his pain medication being discontinued (it was only addressed via written staff informational report two weeks after the incident occurred); and, finally, that the facility review proper procedure for writing medication orders with the dentist.

IV...Facility Policies:

A…Chester Policy TX 02.03.00.02 Unit Dose Preparation and Distribution system states: "The RN/LPN who is responsible for administering the medications on that module will check each patient's current medication orders with the information on the preprinted inlay and the medication and dosage sent from pharmacy using the MAR as the current equivalent of the physician's order. After verifying the recipient, opens the unit dose package and administers the medication. After administering the medication, the nurse then charts the administration on the MAR prior to proceeding to the next recipient."

B. Chester Policy TX 02.02.00.07 Transcription of Medication states: "The licensed nurse who transcribes the physician's order must note the order by signing his/her name, date and time the order was transcribed and is responsible for transcription accuracy to the Medication Administration Record."

"A written order for medication to be administered shall be entered in the patient's medical record on the Physician's Order form by the physician or as a telephone order. The order must include name (generic) of the medication, the dosage, the frequency to be given, the length of time to be given and the method of administration. The nurse transcribing the physician's order is responsible for transcribing the order to the MAR."

"When medications are changed (i.e. dose, time, etc.) or discontinued the transcribing nurse will write 'DC' in the column of the date it is discontinued. The same dated column as well as the rest of the columns for the remainder of the month will be marked through with a yellow hi-liter. 'STOP' is written in the stop column adjacent to the medication. This will identify that the medication should no longer be given. The nurse initially transcribing the physician's order will follow through the entire process. The physician's order, treatment card if used, and Medication Administration Record will be checked for accuracy by another nurse at the time of transcription. The nurse that is checking for accuracy will initial all copies of the orders before sending them to

the pharmacy to be filled. Corrections are to be made as necessary."

Conclusion

Based on review of the recipient's clinical chart, the OIG report regarding this incident and the facility policies relating to medication documentation, it appears that the recipient was given pain medication following his tooth extraction and when the Tylenol wasn't effective, a prescription for Vicodin was written and nursing notes show this medication was given to him. Therefore, the allegation that recipient's pain medication was changed to a less effective medication and given less frequently is **unsubstantiated.** Although no rights violation occurred, the Team noted the following during the course of their investigation: Even though the nursing notes showed that Vicodin was given and also showed when Tylenol and/or Ibuprofen were given, this wasn't always reflected on the MAR sheet. The discontinuation of Tylenol and Ibuprofen that was documented on the MAR sheet was not documented in the nursing notes. Also, the Team found nothing in the records documenting that the doctor had ordered that Ibuprofen not be used for pain management due to abnormal renal function. As per Chester policy 02.02.00.07, the "DC" was written on the MAR for Acetaminophen after the date of 10/25/12. "DC" and the word "stop" was written in the column beside Ibuprofen next to the date of 10/14/12. It was noted that Ibuprofen was ordered for "x 1 now" on 10/17/12. The Team did not find a note on the MAR or in the progress notes in the chart that the physician had ordered that Ibuprofen not be used due to abnormal renal function and Ibuprofen use being determined as the cause. It was only in reviewing the OIG report, where the physician reported this to the OIG investigator, that it was discovered by the Team.

The allegation that the recipient was required to have a urinalysis but did not get the results and then was placed on an antibiotic for a month but doesn't know why is **unsubstantiated**. According to the OIG report, the doctor said that the recipient was told about medication changes. The TPR dated 11/28/12 lists the diagnosis of epididymitis and that antibiotics were given to address this diagnosis. The recipient was present at this TPR and signed his TPR stating he is in agreement with the treatment plan. The nursing notes show no other instances except for the 9/21/12 and 10/18/12 incidents of severe groin pain where a urinalysis was completed. The diagnosis was epididymitis and treatment was Ciprofloxin for 30 days.

Although there were no rights violations, the Authority makes the following **suggestions**:

1. The facility review its policy on medication documentation with the medical staff to ensure clear documentation in the future.

2. The nursing staff and/or doctors make a note in the recipient's chart showing when medical information including changes to medications, test results and treatment options are discussed with the recipient. The facility consider creating/using a form that the recipient can sign when medication information sheets and other medical information is given that states he understands the information. This form should also include a doctor's note indicating he has the capacity to understand and sign said form.

3. During the TPR meeting, there should be discussion of any significant medical issues that have occurred over the last month and what the treatment was. Staff should ensure that the recipient understands the diagnosis and treatment. The TPR discussion section should make note of the fact that a discussion occurred and if the recipient understood the treatment.