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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
Case #13-110-9014

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Chester Mental Health Center:

> **The Authority was concerned about possible overmedication of two recipients based on observations during November 8, 2012 HRA interviews at Chester Mental Health Center.**

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.). Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered to be the most secure and restrictive state-operated mental health facility in the state.

To investigate the allegations, an HRA team interviewed recipients and staff, examined recipient records, with consent, and reviewed pertinent policies and mandates.

COMPLAINT STATEMENT

During interviews with recipients at Chester Mental Health Center, the HRA team observed 2 recipients (referred to in this report as Resident #1 and Resident #2) with whom the HRA had had prior contact; both appeared dazed and lethargic in comparison to prior interactions with the HRA. Each recipient had difficulty tracking conversations and responding to questions. The HRA team immediately notified the facility's human rights committee chair and the facility physician who indicated that they would review the situation of each.

FINDINGS

Interviews

Recipient #1 reported that he takes medications for "mood swings" and because he hears voices telling him to kill himself. He reported that he takes "a whole bunch" of medications twice per day. The recipient's therapist reported that the recipient is temporarily at Chester after being transferred there from another state-operated facility; he is expected to return to the prior state-operated facility in the near future.

Recipient #2 provided little to no response to the HRA team's inquiries. A family member had prior communication with the HRA expressing concern about repeated injuries to Recipient #2 and the HRA was following up on the family member's concerns. The HRA team observed no apparent injuries but did note the recipient's difficulties in communicating and lethargic appearance.

The HRA followed up, by e-mail, with the facility's assistant director of nursing regarding medication concerns. She reported that nursing and clinical staff communicate any recipient issues with the treating psychiatrist, including any signs or symptoms of overmedication. She reported that the clinical nurse managers for both Resident #1 and Resident #2 were consulted and neither indicated any concerns with regard to over medication. It was also reported that Resident #1 has Diabetes which is under control. Resident #2 has high ammonia levels as per lab work. The recipient's psychiatrist is aware of his high ammonia levels and the recipient is receiving treatment (Lactulose) for this. Resident #2 receives routine lab work to monitor the ammonia levels. Resident #2 also has a history of water intoxication and his weight is monitored. Staff also monitor his fluid intake to ensure he does not drink excessive amounts of water. As per staff reports, there have been no major problems with regard to water intoxication for Resident #2. It was also reported that a psychotropic medication review, separate from a treatment planning meeting, is conducted 3 months after admission and then every 6 months after that. Recipients and guardians can participate and receive notice of the meetings at least 7 days in advance. Recipient #1 last had a medication review on 06-18-13 and Recipient #2's last medication review was conducted on 06-25-13. Any disagreements regarding medication recommendations are sent to the facility medical director's attention.

Recipient #1 Record Review

The recipient's 11-21-12 treatment plan reported that the recipient was admitted to Chester from another state-operated facility on 09-05-12 due to four episodes of physical aggression toward peers and an elopement attempt. He had previously resided in a group home where he was physically aggressive toward staff and peers, was an elopement risk, expressed suicidal ideation and reported command hallucinations telling him to jump from a bridge.

At the time of the treatment plan meeting he was not taking court enforced medications but was on involuntary admission status. The recipient's diagnoses included: Personality Change due to Unspecified Encephalopathy, Moderate Cognitive Impairment, and Poor Impulse control. Medications include Haloperidol 10 mg twice per day for psychotic agitation; Lorazepam 2m twice per day and as needed for anxiety/agitation and Divalproex ER 500 mg twice per day for mood lability. The recipient was noted to have some Extrapyramidal Syndrome (EPS) effects so Benztropine was started to address this condition. Emergency treatment preferences were medication and restraints. Treatment goals include medication compliance, a decrease in aggressive behaviors, a decrease in psychotic symptoms, a reduction in mood disorder symptoms, an increase in adaptive behavior skills, activity therapy and rehabilitation programming. The treatment plan indicated that the recipient had been medication compliant and had 2 incidents (10/23/12 and 11/21/12) of aggressive behaviors during the treatment plan period which required restraint use. Other documentation in the treatment plan indicated aggression toward a peer on 11-08-12 which required restraint and verbal threats escalating to a physical struggle with staff on 11-17-12 that resulted in restraints. The treatment plan stated that

a security therapy aide indicated an incident on 11-11-12 and a nurse also reported that "contingency medications" were given for agitation. A psychotropic medication consent form was sign by the recipient; the form indicated that medication education information was provided to the recipient.

A Psychotropic Medication Review conducted on 11-28-12 indicated that the recipient has diagnoses of Diabetes, Cognitive Impairment, Personality Change, Encephalopathy and a History of Seizures. Medications at the time of admission included Haloperidol 20 mg per day; Lorazepam 4 mg per day; Divalproex NA ER 1000 mg per day; Benztropine 1 mg per day; Metformin 2000 mg per day and Omeprazole 20 mg per day; in addition, the recipient was taking as needed (PRN) medications of Milk of Magnesia, Benztropine Acetaminophen, Docusate Sodium. Lab work appeared to be essentially normal. A psychiatrist, nurse and pharmacist signed off on the review indicating that the medications were appropriate with notes to follow Divalprox protocol, obtain Haloperidol level if signs/symptoms suggest toxicity or there are behavioral changes and to evaluate the effectiveness of long-term Lorazepan use. A medication verification/reconciliation form completed at admission indicated that the recipient was on medications that were not recommended to be continued while at Chester, including Clonazepam (a note states will start of Lorazepam), Lamotrigine and Ambien.

Medication Administration Records were reviewed for the months of October and November 2012. The recipient appeared to be medication compliant. While Lorazepam was part of the recipient's routine medications at 2mg twice per day, it was also listed as "contingency" (PRN) medication with a dosage of 2mg. As a contingency medication, it was given on October 2, 6, 11, 14, 15, 18, 21, 22 and 31. November 2012 records continued to indicate medication compliance and contingency medication of Lorazepam was given on November 7, 8 11, 17 and 20. Benztropine began on November 21st at .5 mg twice per day. In December, Haldol was decreased from 20 mg per day to 15 mg per day and later to 4mg per day. However, Haldol was later increased to 6 mg per day in February 2013. In January 2013, dosages of other medications continued, including continued sporadic use of the contingency medication of Lorazepam. Accompanying physician orders indicated that the contingency medication of Lorazepam appeared to have been ordered for agitation.

A psychiatric nursing assessment completed at admission stated that the recipient has slow cognition, stuttering and slow speech,

A mental health evaluation completed on 11-07-12 as part of a certificate for involuntary admission stated that the recipient has psychomotor retardation, appeared sleepy at the time of the evaluation and had slow speech. His thought process was described as "coherent and goal directed." Also noted was the following: "his concentration was somewhat decreased because he appeared to be tired….His intelligence is estimated to be subnormal based on his fund of knowledge….His insight and judgment appear fair. He said he thinks he needs medication and he takes his medication as prescribed…..Since his admission to Chester….[the recipient] had several incidents of aggressive behaviors requiring restraints on 09-13-12, 10-06-12 and 10-18-12. He also flipped over his desk. Besides, he has also needed contingency medications on numerous occasions. He also has poor impulse control…He displays low frustration tolerance and becomes easily agitated…."

A more recent treatment plan from 01-16-13 documented that there had been only one aggressive episode since the last reporting period; the incident involved striking a peer but no restraints were required. The recipient had numerous "Behavioral Data Reports" regarding non-cooperation with procedures, refusals with regard to activities and showering, verbal threats to staff and inappropriate comments to staff. The plan noted that sometimes he was slow to respond to directions due to cognitive functioning, more time needed for the recipient to respond, and the recipient's need for reassurance. The treatment plan indicated that significant reductions in Haloperidol have "…helped to alleviate EPS and apparent sedation. He has recently been displaying a return of some mood stability and rather contentious behavior so a slight and cautious increase in the dose of his Haloperidol was made, and his progress and tolerance will be ongoingly monitored." A treatment plan note regarding mood swings stated that "It is frequently difficult to get him out of bed for required activities as he wants to sleep all day. Since he is not as sedated as he was initially, this may be associated with depression….He seems to sleep a lot. When awakened for meds or meal time, he will at times become angry and threatening towards staff."

The HRA examined a psychotropic medication review completed on the recipient and dated 12-06-12. The review indicated that it was a 3 month review, that the patient agrees with the medication but was not present for the review and that the recipient's response to the medication has been good based on his chart and staff feedback. The panel, which consisted of a psychiatrist, nurse and pharmacist, recommended a continuation of medications; each panel member signed off on the review. The HRA examined the most recent, 6 month review, dated 06-18-13 which indicated the same recommendation, based on the chart, as the 3 month review. The recipient was not present.

Recipient #2 Record Review

The HRA examined the record of Recipient #2 beginning with a treatment plan dated 11-13-12 which indicated that he was admitted to Chester on 05-11-94 as Unfit to Stand Trial for Aggravated Criminal Sexual Assault; He was found Not Guilty by Reason of Insanity on 09-29-96 resulting in confinement for his "natural life." He was also serving a "life sentence" for Attempted Murder. The treatment plan documented frequent behavior data reports related to uncooperative, argumentative and stealing behaviors. The treatment plan also stated that the recipient's ammonia level increased resulting in an increase in Lactulose. A transfer recommendation was referenced resulting in a risk assessment that determined that the recipient was not ready for a transfer to a medium security facility. The following recent behaviors resulting in the administration of PRN medication included: 10-19-12 for taking items from a peer's room; 10-26-12 for being argumentative and having difficulty with redirection; and 10-27-12 for arguing with others and becoming agitated. According to the treatment plan he required seclusion once and PRN medication four times in the past month but no restraints. Assessment history was also documented and most assessments were several years old, including social history (1994), medical history (1994) psychiatric Nursing (1994) and a physical (2009). Diagnoses are listed as Schizoaffective Disorder, Bipolar Type, Disinhibition Personality Changes due to traumatic brain injury in childhood, Antisocial Personality Disorder, Borderline Intellectual Dysfunction, Hepatitis C Positive, Idiopathic Polydipsia, and High Ammonia Level. Medications as of the treatment planning date were documented as follows: Olanzapine 30 mg

at night for psychosis; Topiramate 150 mg 150 mg in the morning and 100 mg at night for mood lability; VPA (Depakote) Syrup 750 mg every morning and 1000 mg every night for mood lability; Clonazapam 3mg three times per day for anxiety/agitation; Haloperidol 10 mg and Lorazepam 2mg as needed for anxiety/agitation; Nicotinic Acid 500 mg three times per day for Dyslipidemia; ASA-EC 325 mg twice per day before nicotinic Acid; Lactulose 30 mg every morning for elevated ammonia. Under the category of "Response to Medication," the treatment plan documented a long history of behavioral needs, medication adjustments and issues related to water intoxication; this section concluded by stating that the recipient agreed to take medications, prefers the pill form, may have his water restriction lifted if he continued to do well with it, may be subject to another transfer recommendation if behaviors improved and may have a reduction in Topiramate in the near future. The treatment plan also stated the following: "We discussed his elevated ammonia level and its apparent effects on him: his speech and thought processes are both slower than usual. He agreed to start taking his lactulose syrup BID to help control it….Increase lactulose to 30 mg PO BID [by mouth twice per day] for control of elevated ammonia with mild mental status changes." Also noted was a prior reduction of Popiramate from 400 mg per day to 250 mg per day. Treatment goals included reducing psychotic symptoms, reducing aggression, control fluid intake to prevent water intoxication, eliminate sexual predatory behaviors, minimize liver damage and lower cholesterol and triglycerides.

The recipient's 02-05-13 treatment plan indicated that his medication and dosages remained the same as the 11-13-12 treatment plan. All other items in the 02-05-13 treatment plan remained the same as the 11-13-12 plan.

Medication records were also reviewed. A consent for the current medications was signed by the recipient on 05-01-12; a nurse and a physician signed off on the consent form as well which indicated medication education information was provided to the recipient. Medication administration records indicated that prescribed medications were given and accepted as ordered. As Needed (PRN) medications were given occasionally. During the month of the HRA's visit with the recipient, PRN medications were given as follows: Haloperidol 2mg on November 14, 2012 and Lorazepam 2mg on November 10, 2012. Medication administration in the surrounding months indicated that PRN medications were given approximately 1 to 4 times per month. A water restriction was documented for the month of March 2012 and a restriction of rights notice was issued. Lab work completed on 09-11-12, 0928-12 and 11-02-12 indicated some abnormalities, most notably the recipient's ammonia level was elevated (143 on 09-11; 94 on 09-28; and, 115 on 11-02); the normal range for ammonia levels is less than 56.

The record revealed that other evaluations were completed including a May 2012 EKG which was normal; a dental exam and extraction in 08-12; nursing assessments; and, a rehabilitation assessment. A referral for a neuro psychological evaluation was made on 09-12-12. An undated file review was conducted in response to overmedication concerns from the HRA's observations; the results indicated the continued need for a neurological exam and lack of dental exams for several years.

Progress notes indicated periodic incidents of agitation, aggression and PRN medication administration. Water intake issues were referenced as well but no clear documentation regarding concerns with medication or medication side effects.

The HRA examined psychotropic medication reviews for the recipient. A 6 month review completed 12-26-12 indicated that the recipient agrees with the medication, was present for the review and is improved. The review panel, consisting of a psychiatrist, nurse and pharmacist, signed the review indicating a continuation of the medication. A 6 month review completed 06-25-13, also with the recipient present, again recommended continued medication.

Policy Reviews

The HRA examined policies pertinent to the allegations. A "Use of Psychotropic Medication" Policy requires that a consent form for psychotropic medication must be signed after an initial assessment and prescription. Medication information sheets are to be provided to the patient. When emergency medication is initiated, consideration must be given for treatment preferences and any deviations are to be documented. Medications reviews are to be conducted by a panel that includes a psychiatrist, pharmacist and either or nurse or therapist.

A "Risk Medication" policy confirms Chester compliance with Administrative code rules 112.80 and 112.90 and indicates that there is a Maximum Daily Dose List issued by DHS regarding certain medications, including Insulin, Clozapine, Valproic Acid, Olanzapine IM, etc.

The facility's "Refusal of Psychotropic Medication" Policy addresses recipient refusal of psychotropic medication and physician notification of the refusal as well as subsequent physician consideration of the need for emergency or court-ordered medication.

A policy entitled, "Medication Compliance," first confirms that recipients have the right to refuse medications unless imminently physically dangerous to self or others. Then, the policy goes on to state that nursing staff who administer medication are to encourage medication compliance, provide medication education, and when issues of non-compliance occur, refer the matter for treatment plan review and interventions. Recipients are to be encouraged to discuss medication concerns and/or questions with the psychiatrist. And, refusals are to be documented in the medication administration record.

The "Psychopharmacotherapy Review for Severe, Continual Physical Aggression" Policy states that "A patient who is identified as violent and difficult to manage will be referred with a Recommendation for Psychopharmacology Review Consult Form…to the patient's psychiatrist and treatment team for review. A copy…will also be sent to the Medical Director. The treatment team will document their response to the…Form and forward it to the Medical Director. The pharmacist will review the patient's previous pharmacological treatment…and then provide the treatment team with information about past responses, failures to respond and side effects. The pharmacist may refer to the antipsychotic algorithm and make general suggestions at the patient's next treatment team meeting….The Psychopharmacotherapeutic Group is composed of one psychiatrist, one pharmacist and one registered nurse." The group's review process consists of asking certain questions including whether medications are consistent with the mental disorder; are symptoms controlled; if not controlled, has the medication algorithm been followed; have medications been given adequate trial; is there a compliance an issue; if there is impulsive aggression, has it been treated with a mood stabilizer or anticonvulsant; are there medical issues; what about a combination of medications as

contributing factors; and, is the patient exhibiting planned, antisocial aggression which may be unlikely to improve with pharmacotherapy. The group then completes a consultation form with recommendations for improved pharmacotherapy.

The facility's "Treatment Review of Medication" Policy states that "When a recipient at a State-operated mental health facility has been receiving psychotropic medications…continuously or regularly for a period of three months, and if such treatment is continued, every six months thereafter for so long as the treatment shall continue, the facility medical director, or other physician designated by the facility director, shall convene a treatment review panel….The facility medical director shall convene a treatment review panel to review the medication. The panel shall consist of representatives from at least two of the following clinical disciplines: psychiatry (with no direct involvement in the treatment/habilitation of the individual), medicine, clinical pharmacy and nursing….At least 7 days prior to the date of the treatment review panel meeting, the recipient, guardian or substitute decision maker, if any, an any person designated…shall be given written notice of the time and place of the treatment review panel meeting….The panel shall review the patient's treatment and medication and document the results of the Treatment Review-Psychotropic Medications review form and provide a recommendation concerning the suitability of continued treatment. If during the course of the treatment review panel meeting, the recipient advises the committee that he/she no longer agrees to continue receiving medication…or if the recipient has a guardian or substitute decision maker and the guardian or substitute decision maker refuses medication….the treatment shall be discontinued except …" under certain conditions which were not clear from the policy. The panel will then make a decision regarding whether or not the medication is to be continued.

The "Patient Rights" policy guarantees the right to adequate care and treatment in the least restrictive environment in accordance with an individualized treatment plan. In addition, the policy guarantees the right to refuse medication. Rights restrictions and appropriate notice are also covered in the policy.

The HRA also examined "Water Intoxication Protocol" which is designed to minimize complications and prevent water intoxication. Recipients must meet certain criteria for the protocol based on a prior diagnosis, certain sodium levels, seizures of an unknown cause or as recommended by the attending physician. Baseline weight and sodium levels are secured and monitored. Interventions include treatment planning, possible transfer to the infirmary or hospital, water intake monitoring and water restrictions. Guidelines for removing the restriction are also incorporated into the policy.

A "Transition of Medication Procedure" governs the documentation of the physician's order for medication and the transcription of the order and any changes on the medication card and medication administration record. The "Unit Dose Preparation and Distribution System" explains how medications are checked by the pharmacist, entered into a computer system, prepared by the pharmacist, delivered to the unit dispensed by the nurse to the recipient, and documented by the nurse. Medications that are refused are wasted in accordance with the facility procedure for wasting medication.

The HRA also examined the Illinois Department of Human Services policy for the administration of psychotropic medication in state-operated facilities. The policy mandates an evaluation prior to prescribing psychotropics except in an emergency and informed consent with distinct procedures for securing consent based on the individual's capacity. Medication refusal is also addressed along with the process for pursuing court-ordered medication. Under the sub-heading of "Therapeutic Use of Psychotropic Medication," the policy states that no order for psychotropic medication is to exceed 30 calendar days and the attending physician is to examine and document the recipient's condition prior to re-ordering, considering the continued appropriateness of the medication. A maximum dosage is identified for each medication and if dosages exceed the maximum, an exemption must be filed and the medication is to be monitored by the facility medical director or pharmacy committee. Prior authorization is also needed when multiple psychotropic medications from the same class are recommended. The policy also addresses the 3 month and then 6 month medication reviews by a review committee with the involvement of the recipient guardian or recipient-designated representative. The HRA noted that in the definitions section of the policy, "emergency" is defined as follows: "An emergency occurs when the individual's mental condition is such that immediate action is necessary to protect the individual or others from harm, or to prevent deterioration of the individual's condition or the individual's death."

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to:

> *...adequate and humane care and services 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. ….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…shall be noted in the recipient's treatment plan….If the services include the administration of electroconvulsive therapy or 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 Code (405 ILCS 5/2-107) guarantees to the right to refuse medication and, if refused, the medication is not to be administered except as follows:

> *…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, guardian, or substitute decision maker, if any, 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….Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to*

the need for emergency treatment are set forth in writing in the recipient's record…..Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record.…Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition.…The Department shall issue rules designed to insure that in State-operated mental health facilities psychotropic medication and electroconvulsive therapy are administered in accordance with this Section and only when appropriately authorized and monitored by a physician or a nurse under the supervision of a physician in accordance with accepted medical practice. The facility director of each mental health facility not operated by the State shall issue rules designed to insure that in that facility psychotropic medication and electroconvulsive therapy are administered in accordance with this Section and only when appropriately authorized and monitored by a physician or a nurse under the supervision of a physician in accordance with accepted medical practice. Such rules shall be available for public inspection and copying during normal business hours.…Under no circumstances may long-acting psychotropic medications be administered under this Section.…The Department shall conduct annual trainings for all physicians and registered nurses working in State-operated mental health facilities on the appropriate use of emergency administration of psychotropic medication and electroconvulsive therapy, standards for their use, and the methods of authorization under this Section.

The Code (405 ILCS 5/2-107.2) outlines a review process with regard to psychotropic medication as follows:

(a) Whenever any recipient, who is receiving treatment in a residential mental health facility, has been receiving psychotropic medication or electroconvulsive therapy in that facility continuously or on a regular basis for a period of 3 months, and, if the treatment is continued while the recipient is a resident in that facility, every 6 months thereafter, for so long as the treatment shall continue, the facility director shall convene a treatment review panel to review the treatment.

(b) At least 7 days prior to the date of the meeting, the recipient, his or her guardian, if any, and the person designated under subsection (b) of Section 2-200 shall be given written notification of the time and place of the treatment review meeting. The notice shall also advise the recipient of his or her right to designate some person to attend the meeting and assist the recipient.

(c) If, during the course of the review, the recipient or guardian, if any, advises the committee that he no longer agrees to continue receiving the treatment, the treatment must be discontinued except that the treatment may be administered under either Section 2-107 or 2-107.1. If the recipient and guardian, if any, continues to agree to the

treatment, the treatment shall be continued if the committee determines that the recipient is receiving appropriate treatment and that the benefit to the recipient outweighs any risk of harm to the recipient.

(d) The Department shall issue rules to implement the requirements of this Section.

The Illinois Administrative Code (59 Ill. Admin. Code 112.80 and 112.90) provides regulatory guidance with regard to the administration of psychotropic medication. Section 112.80 requires that the Illinois Department of Human Services will issue a list of medications and maximum dosages for use in state-operated facilities. A committee consisting of pharmacists will compile this list and conduct annual reviews as well as reviews of newly developed medications as approved by the U.S. Food and Drug Administration.

Section 112.90 requires physician examinations prior to a prescription for Psychotropic medication except for emergency medication which requires a personal observation by the physician or information from a clinician that the recipient is in need of emergency medication to prevent "serious and imminent physical harm to self or others." This section also requires informed consent beginning with the physician determination that a recipient is capable of giving informed consent or if a guardian or substitute decision maker needs to be involved. The section then describes the required components of informed consent including providing the recipient or guardian/substitute decision maker with medication information, medication risks and alternatives, and information about the right to refuse. If refused, the medication is not to be administered except in an emergency and then the facility is to document alternative options to manage an emergency, the actual existence of an emergency, the events leading up to the emergency and the issuance of a restriction of rights notice. Long acting psychotropic medications cannot be administered. The regulations also document requirements for pursuing court-ordered medications, including treatment team determination of the need, a petition filed by the treating physician, a physician's examination and specifics regarding the recipient's need for medication presented to the court.

Section 112.90 also requires that the attending physician monitor the medication at least every 30 days, and staff are to document any additional information such as lab results when the information becomes available. When the recipient has been receiving psychotropic medication for 3 months and then if continued every 6 months after that the facility medical director or other designated physician is to conduct a treatment review with a panel consisting of representatives of psychiatry, medicine, clinical pharmacy and nursing. The recipient, guardian or substitute decision maker or other individual as designated by the recipient shall receive notice of the treatment review panel meeting 7 days in advance indicating the right to attend the meeting. The panel is to determine if continued treatment is warranted. "If, during the course of the treatment review panel meeting, the recipient advises the committee that he/she no longer agrees to continue receiving medication or ECT, or if the recipient has a guardian or substitute decision maker and the guardian or substitute decision maker refuses medication or ECT for the recipient, the treatment shall be discontinued, except when the recipient is receiving treatment pursuant to…." emergency medication administration or court order medication. Panel reviews may result in a continuation of medication and treatment plan revisions. If there is disagreement by the panel members, the facility medical director or lead physician makes the final treatment

decision. Recipient, guardian or substitute decision maker participation and treatment panel recommendations are to be documented in the recipient's record.

CONCLUSIONS

The case complaint contends that two recipients may be overmedicated as observed by the HRA team during a visit to the facility. Both residents appeared to have difficulty communicating and were lethargic in appearance.

In contacts with facility staff, there were no reported concerns of overmedication for either individual observed.

Records reviewed indicated that Recipient #1 had underlying cognitive needs as well as Diabetes which could have contributed to his appearance. Still, treatment plan documentation also noted the recipient's sleepiness and sedation, and, in response, the facility had been significantly reducing the medication, Haldol.

Recipient #2 also had additional needs that may have been contributing to his presentation, including a history of water intoxication and high ammonia levels. According to WebMD, "Symptoms of a high ammonia level, such as confusion or extreme sleepiness, may be treated with a medicine called latulose, a laxative that worked by reducing ammonia production in the intestines." Recipient #2's treatment plan indicated that the recipient's speech and thought processes were slower and it was thought to be related to his ammonia level which was addressed by ordering the medication, Latulose. The HRA did note that for Recipient #2, there were several older medical assessments for this long-term recipient that had not been updated in some time and a referral for a neuro psychological evaluation, dated 09-12-12, had not yet been addressed at the time of the HRA's investigation. A chart review of this recipient by the facility, in response to the HRA's reported concerns, referenced outdated assessments although nothing specific was documented regarding the HRA's concern of overmedication.

Both recipients also had documented reviews of psychotropic medication as per policies and mandates.

The HRA also found that the facility's policies regarding psychotropic medication administration and monitoring appeared to be consistent with Mental Health and Developmental Disabilities Code and the Illinois Administrative Code with the exception of the Department of Human Services' policy definition for emergency being inconsistent with the Mental Health and Developmental Disabilities Code (see Comment below).

Based on the evidence that the facility was monitoring medications and addressing observations of sleepiness and slow cognition by making adjustments in treatment for each of the residents observed, the HRA does not substantiate a rights violation related to medication. The HRA does offer the following suggestions:

1. **Ensure that long-term facility recipients receive updated assessments.**
2. **Ensure that Recipient #2 receives the neuro-psychological assessment as per the 09-12-12 referral.**
3. **When chart reviews are conducted in response to a complaint/concern, document the outcome of the review specific to the complaint/concern.**

Comment: The HRA noted that the DHS policy on psychotropic medication includes a definition of "emergency" and within that definition of emergency there is reference to action needed "…to prevent deterioration of the individual's condition…." The Mental Health Code, when referencing emergency medication, specifically states that emergency medication is only to be used "…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). The DHS psychotropic medication policy definition for emergency is inconsistent with the Code's standards of "serious and imminent physical harm." **The HRA strongly suggests that the facility follow the Code's standard and bring the DHS policy discrepancy to the attention of DHS administration.**

The HRA also questions the reference to "contingency" medications. The HRA was informed by facility staff that PRN medications are typically not used for persons with developmental disabilities. The HRA questions if "contingency" medications are actually PRN medications. Facility representatives also indicated that recipients can refuse the "contingency" medications. The HRA contends that if the "contingency" medications are refused, that the facility should apply the Code standards for emergency medication before administering. The HRA suggests that the facility review the practice of using "contingency" medication.