FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9016
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. A recipient's family was denied access to information even though a release of information was in the file.
2. The facility doctor is not honoring the recipient's right to participate in treatment planning.
3. A recipient is receiving inadequate medical and dietary care.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5).

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… 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 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 pursuant to the provisions of Section 2-107 or 2-107.1…"

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/5) states "(a) Except as provided in Sections 6 through 12.2 of this Act, records and communications may be disclosed to someone other than those persons listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient's record pursuant to Section 4 of this Act.(b) Every consent form shall be in writing and

shall specify the following:(1) the person or agency to whom disclosure is to be made; (2) the purpose for which disclosure is to be made; (3) the nature of the information to be disclosed; (4) the right to inspect and copy the information to be disclosed; (5) the consequences of a refusal to consent, if any; and (6) the calendar date on which the consent expires, provided that if no calendar date is stated, information may be released only on the day the consent form is received by the therapist; and (7) the right to revoke the consent at any time. The consent form shall be signed by the person entitled to give consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. A copy of the consent and a notation as to any action taken thereon shall be entered in the recipient's record. Any revocation of consent shall be in writing, signed by the person who gave the consent and the signature shall be witnessed by a person who can attest to the identity of the person so entitled. No written revocation of consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications."

Investigation Information:

To investigate the allegation, the HRA Investigation Team (Team), consisting of two board 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 the Chairman of the facility's Human Rights Committee (Chairman). With the recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. The Team also spoke with the recipient's uncle who was allegedly denied access to the recipient's information. Finally, the Team reviewed facility policies relevant to the complaints.

Allegation 1: A recipient's family was denied access to information even though a release of information was in the file.

I. Interviews:

A. Recipient: The recipient informed the Team that he did sign a release of information for his uncle so that the facility would share information with him over the phone regarding his care and treatment.

B. Recipient's Uncle: The Team interviewed the recipient's uncle via telephone. He reported that a release of information had been signed by the recipient to allow Chester to speak directly with him regarding his nephew's care and treatment. However, when he called on Thanksgiving, the charge nurse refused to discuss his nephew's treatment and current condition even though she admitted that she saw a release of information in the chart. He wasn't sure what the nurse's name was. He said no one ever contacted him at a later date to provide an update or let him know if there was no longer a valid release in the file. The recipient had since contacted him so the uncle did not pursue the matter any further.

B. Chairman: The Chairman told the Team that Chester follows federal and state laws regarding release of patient information. If the patient would like to have a family member involved in

their treatment, they are given an opportunity to sign a Release of Information which is placed in his chart.

II. Clinical Chart Review:

A…Treatment Plan Reviews (TPRs): The 9/24/12 TPR states that the recipient attended the TPR meeting but continued to be non-communicative. He had been refusing to talk with the psychiatrist and other staff members. He had been observed speaking with a few peers but then returned to muteness when staff approached him. There is no mention of family involvement with the recipient or participation in the TPR.

The 11/19/12 TPR shows that he attended his TPR meeting and had spoken with an aunt and uncle on 11/15/12 and also mentioned that he received packages from his family and that he called them on a consistent basis and they called to check on him regularly during this reporting period. There is nothing indicating that he did not wish for certain family members to have access to his information.

The 12/17/12 TPR states he attended his TPR meeting. He passed his fitness test and had been recommended as fit to proceed with trial and was awaiting a court date. There was mention again of his family contact on 11/15/12 but nothing to indicate any contact since then. It was also mentioned again that he received packages from his family and that he called them on a consistent basis and they called to check on him regularly, but no specific family members are named. There was nothing in the discussion section about his uncle contacting the facility on or around Thanksgiving or if there was discussion regarding a valid release for this uncle.

B. Release of Information: The team found a signed release of information in the recipient's chart for his uncle but the expiration date was listed as October 11, 2012. There was no date listed beside the signature to be able to know when the release was signed. It also had a witness signature, but no date beside that signature either. A second release of information was also found for this uncle with a date beside the signature line of 10/21/12 but this form was not signed by the recipient. An expiration date of 10/21/13 was listed on this release and there was an illegible signature on a line that said "staff person disclosing/obtaining information". There were also three other releases dated 10/21/12 in the file for other family members that were all signed by the recipient and the same staff signature was on those forms as well.

C...Progress Notes: A social worker note on 11/15/12 stated that the recipient called his uncle and then left a message on his Aunt's answering machine.

A social worker note on 11/19/12 stated that the recipient attended his treatment plan review. He had been selectively mute but was talking now. They had no behavioral issues once he started talking. It was noted that the recipient has regular contact with his family and expressed an interest in returning to court as soon as possible. He was given a fitness test to complete and return.

A social worker note on 11/29/12 stated that the recipient spoke with his family regarding the commissary and needing increased calories on his diet and his medication. The social worker

spoke with the recipient's uncle on this date and her note stated "Per the discussion via telephone this writer attempted to address the family's concerns which were 1) commissary times [recipient name] was on the patient phone when the cabinet was opened and he allegedly missed getting his items. Response - He may not have had any items available in the cabinet. 2) Medication being taken away. Response - any questions regarding medication would need to be addressed with [recipient name] psychiatrist who will be available on Monday 12/3/12. 3) Low weight and increased calorie diet. Response - [recipient name] weight fluctuates between 154-158 which is WNL per the dieticians report. All concerns were addressed except medication which the psychiatrist will address should this be the concern."

III...Facility Policies:

A.. Request for Patient Information policy RI .03.05.03.02: states "the Chester Mental Health Center respects the privacy of patient information and abides by federal law (HIPAA) and state law (Mental Health and Developmental Disabilities Confidentiality Act) when dealing with releases of information. A consent for Release of Information, **IL462-0146**, is completed with specific information requested stated on the form, dated and witnessed by the responsible person."

Summary

The Team found two releases of information in the recipient's chart for his uncle; one was signed by the recipient, the other was not. The recipient told the Team that he did want his uncle involved in his treatment. It appears that the releases are renewed annually so it is likely that the signature on the second form may have just been overlooked because the rest of the form is filled out including a signature of a staff person. However, it could also be perceived by a staff person, that the recipient chose not to renew the release the second year and therefore, if information had been released, it would have been a violation of state and federal laws as well as Chester's facility policy on patient privacy. Since the Team didn't have a name of the nurse that the uncle spoke with, we could not question her. The staff signature on the unsigned release is illegible. There were case notes in the chart from the social worker showing that she had spoken to the uncle via telephone to address concerns.

Conclusion

Based on the information that was available at the time of the investigation, the allegation that a recipient's family was denied access to information even though a release of information was available in the file is **unsubstantiated**. Although no rights violation occurred, documentation indicated that at one time the recipient had a release of information for his uncle as well as other family members. For that reason, the Authority **suggests** the following:

1. If there is a question about whether or not a release of information is still valid, the issue should be addressed with the recipient and treatment team to clarify. If it is a valid release, efforts should be made to correct the paperwork and contact the family member as soon as possible in order to allow family involvement in recipient's care and treatment.

Allegation 2: The facility doctor is not honoring the recipient's right to participate in treatment planning.

I...Interviews:

A. Recipient 1: The recipient told the Team that he does attend his treatment meetings. He told the Team that he is taking his medication, but he could not tell us what kind of medication he takes.

B. Recipient's Uncle: The recipient's uncle told the Team that his nephew was not on any medication when he was admitted to Chester; he was on the streets and stealing food. Since being at Chester, he has been taking his medication and is stable, but now the doctor wants to remove the medication for his schizophrenia/bipolar diagnosis and he was unsure what the reason for this was. He was afraid that if this happened, his nephew would be discharged, his condition would deteriorate and he would end up back on the streets without the medication to keep him stabilized. He voiced concerns with the medical director at Chester but she refused to speak with him until he spoke with his nephew's therapist. At the time of our interview, he had not had the opportunity to speak with the therapist.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 9/24/12 TPR stated that the recipient attended his meeting but was non-communicative and it is mentioned that during a previous admission, he also had "selective muteness". It lists his diagnosis as "Axis I Deferred except H/O [History of] Polysubstance Abuse; Axis II H/O Antisocial Personality Disorder; Axis III Deferred; Axis IV multiple arrests; substance abuse; H/O violence against others." Under Response to Medication, it states that he is not on medication. The TPR also states that he is not able to consent to or verbally accept medication. He was in restraints a total of 31 hours 9/1/12 - 9/30/12. The patient refused to sign his TPR.

The 11/19/12 TPR stated that the recipient attended his meeting. He was in restraints for aggressive behaviors. He was not talking but his behavior was very "bizarre". Labs were drawn and his electrolytes were critical and he was moved to the infirmary. Within 48 hours he was talking for the first time since admission. He had taken the fitness test and passed. He requested to return to court as soon as possible. His diagnosis was listed the same as in his 9/24/12 TPR. His current medication and intended outcome is listed as "Decreased Olanzepine to 5 mg am and 10 mg hs (for atypical psychosis and behavior including impulsivity and acting out) was changed from enforced emergency to regular since he accepted medication when offered without being enforced." Under Response to Medication, it states that he is not on medication but also states that at his 10/23/12 TPR he was started on emergency enforced medication but then agreed to consent to medication. The TPR states that he was in restraints 31 hours in September, 8 hours in October and 4 hours in November. He has had no problems since 11/14/12. There was no signature page included in HRA's copy to be able to determine if the recipient signed his TPR or not.

The 12/17/12 TPR stated the recipient attended his treatment plan review meeting. He had passed his fitness exam and was awaiting a court date at that time. His diagnosis was listed the same as in his 9/24/12 and 11/19/12 TPRs. The Response to Medication section stated verbatim what 9/24/12 and 11/19/12 TPRs stated and then added was "12/17/12 TPR: He continues to function very well and no longer has trouble communicating (very verbal in expressing his thoughts and feelings). His actions are rational and he thinks very logically. He was recommended as fit to stand trial and he agrees and is very pleased." The TPR also listed an update on 12/17/12 "He is currently on no psychotropic medications due to absence of psychosis. He spontaneously improved." The recipient signed his TPR.

B. Medication Orders: Admission orders on 9/5/12 state that the recipient is on no psychotropic medication and that he will be evaluated soon for emergency medications. The only medication orders for that date are for acetaminophen, milk of magnesia and docusate sodium as PRN medications.

A 10/15/12 order lists PRN medications of "Lorazepam 2 mg PO daily for agitation and 2 mg/ml-1ml inj for severe agitation"

A 11/22/12 order lists PRN medications of "Lorazepam 2 mg PO daily for agitation and 2 mg/ml-1ml for severe agitation and also lists Olanzepine 10 mg tab PO daily for Atypical protocol."

A 11/28/12 order states "reduce Olanzepine to 5 mg am + 10 mg h.s. X 3 days reduce (illegible) to 10 mg h.s. X 3 days then 5 mg h.s. X 1 week then D/C."

A 1/1/13 order lists PRN medications of "Lorazepam 2 mg PO daily for agitation and 2 mg/ml-1ml inj for severe agitation"

C. Medication Administration Records (MAR): The September 2012 MAR lists "Emergency Enforced Olanzepine 10 mg IM X 1 now" on 9/5/12 and initials indicate it was given at 9:00 p.m. An order for "Lorazepam 2 MG IM X 1 dose now emerg enf" was listed on 9/18/12 and initials indicate it was given at 8:35 a.m. Also listed is "Haldol 10 MG IM now emergency enforced" on 9/19/12 initials indicate it was given at 4:30 p.m. and "D.C." is listed beside it. Another order for "Lorazepam 2MG IM X 1 now" was listed on 9/28/12 and initials show it was given at 4:55 p.m. The only other listings are the PRN's of Milk of Magnesia, Acetaminophen and Docusate Sodium, Lorazepam 2 mg PO q 6 hours PRN for agitation and Lorazepam 2 mg IM q 6 hours PRN for severe agitation but there are no initials indicating that any of these were given this month.

The November 2012 MAR lists "Olanzepine 10 mg tab PO daily crush and observe" and initials indicate it was given every day at 9:00 a.m. and 9:00 p.m. "Emergency Enforced 10 mg IM Olanzepine" is listed on 11/2/12 and initials indicate it was given at 1:40 p.m. The orders for "Olanzepine 5 mg X 3 days at 9:00 a.m. and 10 mg X 3 days at 9:00 p.m." are also listed and initials indicate they were given on 11/29/12 and 11/30/12. Both Olanzepine orders were finished in December, 2012 as per the doctor's orders tapering to discontinuance.

The January 2013 MAR lists the same PRN medications of Lorazepam 2 mg PO for agitation, 2 mg/ml INJ, acetaminophen, docusate sodium and milk of magnesia with no initials indicating any were given during this month.

D. Nursing Summaries: The summary dated 9/12/12-9/18/12 noted "pt very defiant argumentative uncooperative with facility and module rules. Very paranoid."

The summary for 9/19/12-9/25/12 noted on 9/9/12 the doctor ordered "emergency enforced X 1 Haloperidol 10 mg IM now for psychosis/bizarre behavior." Also stated was "pt remains very defiant uncooperative with facility and module rules requiring numerous episodes of restraints and emergency enforced medications."

The summary for 10/3/12-10/16/12 stated "patient required restraints X 1. Patient's repeated stealing from others requires much redirection from staff."

The summary for 10/17/12-11/17/12 noted that the doctor restricted him to the unit and will review his progress every 2 days. On 10/18/12 the doctor ordered "emergency enforced medication Olanzepine 10 mg PO BID for agitation/nonverbal psychosis if refuses give IM." The order was reviewed every day until 10/22/12 when he ordered "Olanzepine 10 mg am and h.s." on 11/2/12 another emergency enforced medication of "Olanzepine 10 mg IM now" for aggression and agitation and ISTAT was ordered. It was discovered he was water intoxicated and he was sent to the infirmary. The nursing note stated "pt required multiple PRNs and emergency enforced medication. 1 episode of restraints; was discovered he was water intoxicated. Max body wt was recalculated, behavior has much improved." He was given education on medication, water intoxication and diet. It was noted he attended 3/3 "participation was good."

The summary for 11/18/12 - 12/11/12 stated "pt restraint and seclusion free. Requires redirection on occasion." The doctor reduced Olanzepine to "5 mg am and 10 mg h.s. X 3 days then 10 mg PO h.s X 3 days then 5 mg h.s. X 1 week then D/C". His water intoxication protocol was followed and weight was monitored.

The summary for 12/12/12 - 1/9/13 stated "behavior controlled, did not require use of emergency interventions, quiet, up on module. Interactions with others are appropriate." The water intoxication protocol was discontinued as behaviors and labs confirmed he was not water intoxicated. Excess weight was determined to be due to appetite.

E. Progress Notes: A 11/2/12 9:00 a.m. (late entry) case note states "pt noted to this writer that 'I don't want any meds, I refuse.'"

A 11/2/12 case note said the recipient stole a packaged food item off the stem desk. Staff asked him to put it down but he took off running. He was placed in a physical hold at 12:55 p.m. and at 1:00 p.m. was placed in FLR cuffs. At 1:40 p.m. the doctor ordered emergency enforced medication of Olanzepine 10 mg IM due to aggression and agitation. An Istat was ordered at 1:40 also due to pale yellow urine. At 2:20 p.m. the results were reported by the lab. At 2:56 p.m. the doctor ordered admission to the infirmary for water intoxication protocol due to critical

labs. A late entry states that at 1:40 p.m. Olanzepine 10 mg IM was given and a restriction of rights was given to the recipient. At 4:30 p.m. the recipient refused supper but drank milk. The next several notes show where labs were repeated and water intoxication protocol continued.

A 11/3/12 nursing note says the recipient was cooperative with medication, reported mild light-headedness, had a steady gait, was alert, and had no other complaints.

A 11/5/12 nursing note states the recipient was cooperative with medication and ate his evening snack.

A 11/7/12 nursing note at 8:30 a.m. states that the recipient refused his medications and breakfast and will not speak. The doctor was called about refusals. A psychiatrist note at 10:40 a.m. noted that he was on water intoxication protocol and it had been reported that he refused medications for 2 days and did not eat 2 meals. The doctor also noted that the recipient didn't verbalize but used sign language to communicate. The note states "no change in behavior, behavior is intentional nonverbal not catatonically mute - atypical psychosis." A nursing note at 8:45 p.m. said the recipient accepted medications. There are no other notes indicating that he ever refused medications again.

On 11/28/12 a psychiatrist note states that "the recipient made a sudden and swift change (improvement) with his nonverbal/mute behavior." When asked what his reason for not talking since admission was, he admitted that "he wanted to be that way until his parole date be expired." He took a fitness test voluntarily without much help and scored 100%. The doctor went on to say "He is not mentally ill, his behavior was purposeful. May not benefit from psychotropics. He is mentally stable and will be recommended as fit to ST TR [Stand Trial] Recom reduce Olanzepine gradually until D/C. See Drs Orders."

A 12/26/12 psychiatrist note states "D/C [Discontinue] water protocol. He gained wt from eating more due to meds effect."

F. Discharge Summary: The 1/14/13 summary stated that "according to the record that accompanied the recipient, he was UST and was given a diagnosis of schizophrenia, paranoid type, rule out malingering." Upon admission the recipient was unpredictable and totally nonverbal. According to the summary, he needed an initial psychiatric evaluation and an order for restraints due to him refusing to follow routine rules and regulations, particularly the admission process. He was placed in restraints "because of his unpredictable behavior, particularly with recent history of being aggressive." The record indicated that he attempted to strangle his cell mate at the county jail. The summary also stated that at county jail, he refused all treatment including psychotropic medication; he urinated in the day room, was non-communicative and spent a lot of time sleeping in his cell. The recipient had one previous psychiatric admission in 2007 but there was no diagnosis given at that time due to the lack of proper evidence. Clinically, he did not present any "hard core symptoms of psychosis." He was not treated with any medication and was very nonverbal and mute at that time but quickly recovered within 24 hours and later became cooperative, talked, became fit to stand trial and was returned back to county jail. The summary stated that physically he appeared to be undernourished upon admission. The discharge summary stated that "all psychotropic

medications (Olanzepine) were gradually decreased and discontinued without any changes in his mental status. His Axis I diagnosis has 'no mental disorder' and he is not aggressive and has not been in restraints."

III...Facility Policies:

A. Psychotropic Medication Policy 02.04.00.02: states "Chester Mental Health Center prescribes psychotropic medication in accordance with Department of Human Services PPD 02.06.**01.02**". Initially, the team could not find the DHS policy referenced in Chester's medication policy. Upon request, Chester provided the HRA with a copy of DHS policy 02.06.**02.020** which includes a definition of emergency which states "…to prevent deterioration of the individual's condition…." The HRA then found an older version of DHS policy 02.06.**01.020** which defines emergency as "an impending or crisis situation which creates circumstances demanding immediate action for preservation of life or prevention of serious and imminent bodily harm to the recipient or others." 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).

B. Treatment Plan Policy 03.01.01.03: states in the "participants" section: "Identify the names and titles of all participants. A psychiatrist, registered nurse, and coordinating therapist must be present to hold a treatment plan meeting. Other specialized staff determined by the specific needs of the patient may participate, including a pharmacist at the 3-day treatment plan meeting. Unit Security Therapy Aide staff assigned to the unit need to be present at the meeting. It is desirable that the patient and all staff involved in the treatment of the patient be present. The Treatment Plan should indicate whether the patient was in attendance and if not, indicate reason(s). The patient should be actively involved in the choice of treatment goals and interventions. If the clinical condition of the patient restricts his ability to participate in the treatment planning process, helping the patient achieve readiness for involvement in the treatment planning process becomes a goal. Indicate whether the legal guardian (if applicable) or family members attended or participated by phone and if not, why not."

In the "discussion" section it states: "Provide information from the patient indicating if the patient was or was not in agreement with the treatment plan and any comments the patient writes on the Participants in Treatment Plan form (CMHC-757). Describe the team=s observations of the patient as he presented at the team meeting, i.e., physical condition, emotional state, presence of hallucinations, delusions, signs of cognitive disturbance and behavioral problems."

Summary

The TPRs stated that the recipient attended his TPR meetings and his signature was on at least one of the TPR reports. The HRA noted a discrepancy in the TPRs. Under "Response to Medication" it stated that the recipient was not on medication, however under "Current Medication and Intended Outcome" it listed medication that he was on. When comparing the TPRs to the case notes and the MARs, the Team was able to determine when his medication began and ended. The psychologist's note dated 11/28/12 stated "He is not mentally ill, his

behavior was purposeful. May not benefit from psychotropics. He is mentally stable." The recipient took a fitness test and was recommended as fit to stand trial and has since been released from Chester back to county jail to stand trial. There was no documentation indicating that the recipient ever requested to be on psychotropic medication, only the case note dated 11/2/12 which stated that the patient said "I don't want my meds, I refuse." He was given forced medication initially and then he eventually complied with taking his medications until the psychiatrist determined he was not mentally ill and no longer needed them. Case notes and TPRs after the discontinuation of psychotropic medication made no note of the recipient having any behavioral issues after the medication was discontinued. The nursing summaries dated after the medication was discontinued stated "behavior controlled, did not required use of emergency interventions, quiet, up on module. Interactions with others are appropriate."

Conclusion

The records indicated that the recipient attended his TPR meetings and when he discontinued his "selective muteness" the notes indicated that he participated in his meetings. The Team found nothing indicating that the recipient asked to be placed on psychotropic medication and was denied. The facility doctor placed him on psychotropic medication when his diagnosis and behavior warranted such, but then discontinued the medication when the recipient admitted that his muteness was intentional until his parole date passed and he showed no other signs of mental illness. The notes indicated that he had no adverse reactions once the medication was discontinued. The recipient has since been found fit to stand trial and has been discharged from Chester. Therefore, the allegation that the facility doctor is not honoring the recipient's right to participate in treatment is **unsubstantiated**. The HRA would like to take this opportunity to make the following suggestion.

- Although the TPRs reviewed by the HRA for the months of September and November stated that the recipient was present at his TPR meeting, they failed to mention if he agreed with his treatment plan as stated in Chester's policy 03.01.01.03. It was stated in the September TPR that he refused to sign his TPR. November's TPR was missing the last page so the Team could not determine if he signed, or refused to sign that month or if he agreed or disagreed with his treatment plan. Chester should ensure that the TPRs include a statement as to whether or not the patient agrees with his treatment plan.

During the course of its investigation, the HRA found a discrepancy between the DHS policy's definition of "emergency" and the Mental Health Code's definition. In addition, the HRA found several documented statements that the recipient was given emergency medication and was restrained for reasons that did not appear to meet the Mental Health Code standards for emergency medication and restraint. Examples include: 09-09-12 Haloperidal given for psychosis and bizarre behaviors; 10-3-12 to 10-10-12 restraint use for repeated stealing; 10-18-12 emergency medication given for agitation and psychosis; and 11-02-12 emergency medication given for aggression and agitation. The HRA strongly suggests the following:

- The facility should follow the Code's standards for administering psychotropic medication and applying restraints. The facility should revise its psychotropic

medication policy (02.04.00.02) to reflect the Code's definition of "emergency" to ensure that medication is only being given "…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 facility should also ensure that it follows the standard for restraint use which is "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." (405 ILCS 5/2-108).

- Bring the DHS policy discrepancy to the attention of DHS administration and redefine "emergency" accordingly.

- Patient information regarding medications should be handed out when psychotropic medication is given to recipients and steps should be taken to ensure the recipient understands what medication he is being given and possible side effects as per the Code (405 ILCS 5/2-102).

Allegation 3: A recipient is receiving inadequate medical and dietary care.

I. Interviews:

A. Recipient: When the team spoke with the recipient, he told us that he would like to have more to eat than what he is presently getting. He said he had not yet asked to see a dietician, but that he would. As mentioned above, he also said he was taking medications, but could not name which medication he was taking. He said that he does attend his TPR meetings to discuss his treatment.

B. Recipient's Uncle: The recipient's uncle voiced concern to the HRA that his nephew looked underweight and malnourished during a recent visit and he was concerned that he wasn't getting proper medical and dietary care.

C. Chairman: According to the Chairman, Chester Mental Health policy states that all special diets are ordered by a Physician and monitored by the Dietary Manager. Recipients' dietary requests are considered, however, review by the Dietician and approval by a facility Physician is necessary before the diet is implemented. The Patient's medical treatment is discussed at the treatment plan review (TPR) meetings and a course of treatment is determined by his treatment team which includes the recipient and the treating physicians.

II. Clinical Chart Review: The recipient's medical information is detailed above in allegation 2. Therefore the following information is what the Team found in the recipient's chart regarding dietary care.

A. Weight Records: Upon admission, the recipient's weight was 150 pounds. His dietary consultation at admission showed his ideal body weight range as 155-189 pounds. He gained 10

pounds during his first month at Chester. He was weighed frequently due to being on water intoxication protocol. Throughout the months of September, October and November, his weight fluctuated between 150 and 160 pounds. In December, his weight had increased to 178 and his last recorded weight on 1/2/13 had him at 192. On 12/5/12 his weight had increased to 178. On 12/26/12 his weight was recorded as 186 and on 1/2/13 it was 192.

B. Nutritional Assessment: On 9/18/12 the recipient had an initial nutritional/dietary assessment. The dietician calculated his caloric needs and determined that he was "below his ideal body weight" but his "BMI was 20.9 (normal, acceptable)". His estimated nutritional needs were calculated at 2386 calories per day for weight gain. It was determined that his current regular diet adequately met his needs.

On 12/3/12 the recipient was seen by the dietician for "complaints of hunger". His present weight at that time was 169 pounds. It was noted that his ideal body weight was 155-189 pounds and that he was on water intoxication protocol with maximum body weight of 176 pounds. The dietician reviewed and stated that the regular diet was adequate to meet his needs. It was also noted that the patient has funds for commissary. The dietician recommended continuing his current plan, no diet changes were made.

C. Case Notes: A 11/2/12 case note stated that the recipient refused supper but consumed 240 cc's of milk.

Notes for 11/3/12 through 11/5/12 stated that he ate well for all meals. On 11/6/12 he refused his noon meal and refused supper 3 times. He also refused breakfast on 11/7/12. The doctor was notified. He ate 100 % of his meal at noon on 11/7/12. There were no other notes indicating that he refused meals after 11/7/12.

A 12/3/12 social worker note stated that "his weight on 11/16/12 was 154 pounds. His weight loss was mainly related to his refusal to eat meals on occasion. He is doing much better and his weight is now 174 pounds. He will remain on a regular diet."

On 12/5/12 at 7:30 a.m. there is a note that states "pts wt 178#" Another note at 8:45 a.m. states "pts wt 182# 4# increase from this morning and 6# above IBW of 176. Dr orders STAT e-lytes to be drawn." At 9:20 a.m. the note states "results of stat e-lytes…all values within normal limits no further orders."

On 12/6/12 at 8:00 p.m. a nursing note states "patient is 4# above his maximum body weight of 176# but exhibits no behavior changes. This was discussed with unit nurse supervisor and it was decided that if patient did not exhibit behavior changes electrolytes should not be drawn."

A 12/11/12 nursing note at 9:00 p.m. states "Weight 188# - no behavior problems, patient denies any problems."

12/21/12 note at 7:40 a.m. states "pt wt is 195#, IBW is 176#, dr notified and order received for stat e-lytes per H2O protocol." A note at 8:00 a.m. notes the results of the stat e-lytes and at 9:10 a.m. the doctor ordered "to turn water off to room." At 9:15 a.m. a restriction of rights notice

was given to the recipient for turning the water off. A note at 1:30 p.m. stated "pt wt this afternoon remains at 195# no adverse behavior noted, pt calm and cooperative."

12/22/12 note states "wt this am was 184, up pacing module, behavior controlled, no (illegible) behavior noted."

On 12/24/12 at 11:00 a.m. the doctor followed up on water intoxication protocol. The doctor's note is illegible. A nursing note at 10:45 a.m. stated that the recipient was seen by the doctor and the order was renewed for follow up labs and urinalysis. At 1:55 p.m. the lab called with the results and it was noted "no orders received." On 12/26/12 a psychiatrist note states "D/C water protocol. He gained wt. from eating more - due to meds effect." A nursing note at 9:15 a.m. notes to discontinue water protocol.

III. Facility Policies:

A. Water Intoxication Protocol Policy 06.00.00.07: Patients who meet any of the following criteria can be placed on water intoxication protocol: "A) Those with a previous diagnosis and no justification for omitting the diagnosis; or B) Patients with a sodium level of 125 meq/liter or less within previous year; or C) Patients with seizures of unknown causes suspect water intoxication); or D) Any patient suspected by the attending physician as appropriate for therapy." When placed on water intoxication protocol, it states that "the patient is kept on their unit, nursing staff are informed and the patient's weight is taken morning and evening and when staff deems necessary due to patient's symptoms." Maximum allowable body weight is calculated by a formula that is listed on the policy and if the patient reaches their maximum allowable body weight, a serum sodium level is taken. Interventions include: "water restriction for a specified period of time (including turning water off in his room), 1:1 observation, seclusion, restraints or other measures as appropriate."

Summary

The recipient was placed on water intoxication protocol on 11/2/12 due to his weight gain and Istat lab results. The facility kept him on this protocol until 12/26/12 and monitored him regularly. The doctor's orders stated "D/C water protocol he gained wt from eating more due to meds effect." When the recipient complained of hunger, he was referred to the dietician for evaluation. The dietician made no dietary changes due to his being within his ideal body weight. It was documented in the recipient's chart when he refused meals and the doctor was notified when he refused more than 2 meals.

Conclusion

Based on the information that was reviewed, the Team determined that the recipient received medical and dietary attention when issues came up. Therefore, the allegation that the recipient is not receiving adequate medical and dietary care is **not substantiated.**