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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
Case #13-110-9021

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

1. **A recipient's elbow injury was not treated properly.**

2. **A recipient's rights were inappropriately restricted.**

3. **The facility did not honor a recipient's right to participate in treatment planning.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.). Chester Mental Health Center is a state-operated mental health facility serving approximately 240 recipients; it is considered the most secure and restrictive state-operated mental health facility in the state. To investigate the allegations an HRA team interviewed a service recipient, interviewed facility staff, examined a recipient's record with consent and reviewed pertinent policies and mandates.

COMPLAINT STATEMENT

According to the complaint, a recipient had an injured elbow that resulted in a large fluid-filled sac protruding from his elbow for which he received little to no treatment, including no drainage, which seems to be worsening. The complaint stated that the recipient is only receiving Tylenol for the condition. Also, the complaint stated that the recipient was placed on 1:1 staff supervision for physical aggression with a peer but staff documented that the recipient was on suicide watch. The recipient reportedly never threatened suicide but because of the staff documentation regarding suicide watch, all of his belongings that would be considered dangerous for an individual on suicide watch have been taken away. The complaint also stated that the recipient is facing a medication reduction over the recipient's objection who contends he is currently on a therapeutic dose.

FINDINGS

Staff Interview

In response to the HRA's inquiry the internal human rights committee chair investigated and reported back to the HRA about the recipient's elbow. The chair stated that he reviewed the recipient's chart and spoke to the recipient, a nurse and the therapist. The recipient indicated the he had hit his elbow on a desk as documented in an injury report. The report also stated that the recipient was examined by a physician after the incident and provided first aid. This occurred in September 2012. On 11/28/12, the recipient was examined by another physician who indicated that the fluid in the elbow would absorb itself after which another physician examined the elbow and concurred with the first physician. The recipient verified receiving medication for pain relief as per the chair. The chair also indicated that "The elbow is obviously swollen with fluid." The chair stated that the recipient wants the fluid drained, however the physicians state that the fluid will only return after any drainage as per the chair.

Record Review

The recipient was admitted to the facility on 07-23-09. His initial treatment plan dated 07-24-09 indicated that he had been readmitted to Chester from Cook County Jail as Unfit to Stand Trial for a murder charge. The recipient reported during his treatment team meeting that he fights with peers, that he attempted to hang himself while in jail, that he had a seizure while in jail, that he hears voices and that he has trouble sleeping. His admitting diagnoses included: Malingering, Antisocial personality Disorder, and Seizure Disorder. He was described as being a high risk of dangerousness, physically aggressive towards peers/staff and having a history of aggression and suicide attempts. His medications at the time included Zyprexa 12mg, Seroquel 640 mg; Zoloft 20mg; Klonopin every am and 2mg at night; Effexor 7mg; Dilantin 30mg; Nifedipine VL 6mg; Haldol 5mg every 4 hours; Naproxin 375 mg every 8 hours and Ativan 2mg every 4 hours PRN (as needed). According to the treatment plan, the recipient's aggressive behaviors persisted in spite of the medication and the patient stated that the as needed medication alleviates voices and helps with suicidal thoughts. The drug reduction plan stated that the "Patient refuses to have medication changed at present. Has repeatedly become even more violent when medication change is brought up." Emergency treatment preferences included 1) restraint; 2) emergency medication; and, 3) seclusion. Treatment goals consisted of reducing aggressing and achieving fitness to stand trial. The recipient attended the treatment plan meeting.

The recipient's treatment plan dated 01-25-13, under the restriction of rights section, referenced an incident in which the recipient's "Desk removed from recipient's room with personal property to be retained in recipient closet. This was initiated due to the increased risk of self harm. [The recipient] had been on 1:1 observation from 01-17-13 to 01-25-13 due to increased risk of suicidal behavior. He has a history of prior suicide attempts with property. The restriction of rights is valid until 02-25-13." It was also noted that he threatened a peer on 01-01-13, struck a peer twice on 01-03-13 and struck a peer on 01-04-13. He received as needed medication on 01-05-13 at his request and refused medication on 01-17-13. According to the notes, the recipient refused Quetiapine stating it was not properly made so the pharmacy was contacted for another pill but he became angry and still refused it and another medication. Because he was on court-ordered medication he was given 10mg of Olanzapine intramuscularly per the court order and placed on 1:1 observation due to increased suicide risk. The treatment plan's documented justification for the suicide precautions stated that: "In the past when he refuses his medication he has attempted to hang himself." On 01-22-13 Clonazepam was increased to 4mg per day and Quetiapine was changed to 600 per day. He was reported to be stable on 01-25-13 and his 1:1

observation status was discontinued and replaced with frequent observation. His diagnoses were listed as Major Depressive Disorder, Antisocial Personality Disorder and Anoxic Brain Injury from a 1996 suicide attempt by hanging. Medications prior to the 01-22-13 changes were Quetiapine 800mg per day; Sertraline 200mg per day; Effexor-XR 300 mg per day; Clonazepam 3mg per day and Trazodone 450 mg per day. The treatment plan indicated several medication increases since admission. According to treatment plan documentation, the recipient complained of left elbow pain during a 10-31-12 treatment planning meeting after which an x-ray was done that indicated no fracture and then notes from a 11-29-12 treatment plan meeting stated that he had bursitis on his elbow causing him discomfort for which he had been seen by two medical physicians who reported that it would gradually heal and prescribed pain medication. The plan documented a suicide attempt at Chester on 04-19-12 when he was found hanging by his bed sheet from his room door but with no injury, a 1996 suicide attempt in jail that resulted in an anoxic brain injury, and physical aggression on 07-30-12, 11-17-12, 01-03-13 and 01-04-13. The HRA did not find goals/objectives specific to the bursitis. The recipient participated in this treatment plan meeting.

The recipient's 05-13-13 treatment plan indicated that his medications remained stable and there did not appear to be plans to change them. Aggression was documented on 03-31-13, 04-07-13, 04-09-13 and 05-11-13. There was no documentation about recent suicide attempts or 1:1 observations. And, there was no documentation regarding the condition of the elbow. A unit change and dissatisfaction with his current psychiatrist were noted. The recipient refused to participate in this treatment plan meeting.

Restriction of Rights Notices were reviewed as well. A restriction notice dated 01-17-13 stated that the recipient was restricted from his desk and property from 01-17-13 at 8:45 am to 02-17-13 at 8:45 am. The reason given was as follows: "Desk and property removed due to concerns regarding self harm. Client has prior suicide attempts with property." A restriction dated 01-28-13 stated that the recipient was restricted from desk and other personal property from 01-28-13 at 11:15 am to 02-28-13 at 11:15 am for the following reason: "Property, except Walkman, removed and stored on unit due to concerns regarding self harm. Prior suicide attempts with property." And, a restriction notice dated 01-29-13 stated that the recipient was placed in seclusion because "Recip unable to state he will not physically harm others. Poses a significant risk of physical violence to others." Seclusion rather than restraint or medication (the recipient's preferred emergency treatment) as it was "offered and accepted" by the recipient.

A psychotropic medication review was conducted on 04-03-13 documenting that the recipient's current medications were appropriate. A psychiatric evaluation was conducted on 04-09-13 after an incident in which the recipient was "severely" aggressive towards another recipient. The psychiatrist noted that the actions were not symptoms of his mental illness but rather related to an argument over television programming; the psychiatrist noted that the recipient's mental illness remains stable with his current medications. A forensic evaluation regarding the recipient's fitness was conducted on 12-20-11 with no conclusive results although his history of suicide attempts was documented.

Progress notes from 11-15-12 through 01-29-13 were reviewed. Notes on 11-17-12 indicated that the recipient struck a peer in the head and abdomen for an unknown reason. The recipient

was given Benadryl for complaints of itching skin on 11-25-12. On 11-28-12, the notes stated that the recipient complained of fluid in his elbow; the notes stated that the recipient has seen the physician several times with the physician stating that the fluid "will absorb itself" which the physician and other staff have reinforced. A 12-05-12 psychiatric note stated that the recipient has had bursitis in his elbow which has been evaluated by two physicians who reassure him that it will gradually heal. Pain medication was also noted. On 12-07-12 the recipient took PRN medication when he reported feeling agitated and spoke of wanting to strike a peer. The recipient complained of elbow pain on 12-11-12 for which he received pain medication. Complaints of elbow pain continued on almost a daily basis through December and the start of January. The recipient was given pain medication each time with subsequent nursing checks to ensure the pain medication was effective. The recipient threatened a peer on 01-01-13 and the peer was removed; the recipient was in two altercations with a peer on 01-03-13, self defense may have been a factor. The recipient was subsequently placed on frequent observation due to the aggression which was discontinued on 01-07-13. He had more complaints of elbow pain on 01-10-13, 01-11-13 and 01-15-13 for which he received pain medication. On 01-17-13 the recipient became upset when staff needed to call the pharmacy regarding one of his medications, Quetiapine which had a manufacturer's flaw, and then refused this court-ordered medication. The treatment team then decided to place him on 1:1 suicide watch "…due to H/O [history of] suicide when refusing PO meds." The physician noted his attempt to talk with the recipient and the patient refused to talk or make eye contact after which the physician ordered 1:1 observation for safety indicating the recipient's history of hanging himself when upset. One on one observation continued through 01-25-13 at which time the recipient was placed on frequent versus 1:1 observation. The physician's order indicated that the recipient may stay in "regular room" with "regular bedding." On 01-29-13, the recipient and a peer had a verbal confrontation, took on fighting stances and then were effectively separated. According to the notes the recipient agreed to take a PRN medication. The treatment team immediately met and interviewed the recipient who indicated that he may consider retaliation against the peer. The psychiatrist reviewed the situation indicating concern that the recipient has a history of violence that results in serious injuries and ordered seclusion. Suicide risk was also assessed at that time but the greater concern was for violence against the peer.

A review of medication administration records from May 2013 indicated that pain medication was given on May 28th, Triamcinolone cream for a rash was administered twice per week, an antibiotic was given for 7 days, Prednisone was given 15 days, a second antibiotic was given for 6 days and Benadryl was given for 3 days. It appears that psychotropic medication was being given as prescribed and as court-ordered; there had not been any recent changes to reduce psychotropic medications as per the administration orders. Although treatment plans document medication changes and increases since admission, more recent treatment plans for January and May 2013 indicate no current plans to reduce any medications.

A radiology report dated 10-23-12 indicated that an x-ray was done of the recipient's left elbow with a note that the recipient "indicated he hit elbow on the dresser. Some swelling." The results stated that there was soft tissue swelling but no fracture.

In an on-line review of Bursitis as per WebMD, Bursitis is described as "…the inflammation or irritation of the bursa. The bursa is a sac filled with lubricating fluid, located between tissues

such as bone, muscle, tendons and skin, that decreases rubbing, friction and irritation….Bursitis is most often caused by repetitive, minor impact on the area, or from a sudden, more serious injury. Age also plays a role. As tendons age they are able to tolerate stress less, are less elastic and are easier to tear." The website also states that Bursitis affects the elbow as well as other joint areas and the most common symptom is pain. Treatment may include avoiding activities, rest, icing and taking anti-inflammatory medication.

Policy Review

The HRA team reviewed policies pertinent to the complaints. Policies that govern medication administration, including psychotropic medication, indicate that persons receiving psychotropic medications are subject to treatment reviews every six months by a review panel that consists of representatives from psychiatry, pharmacy and nursing. The review panel determines the extent to which current treatment remains appropriate as well as medication risks and benefits. If the panel does not concur with the current treatment regimen, the treatment team will consider a revision. If there is disagreement the facility medical director intervenes. The recipient and guardian are included in the review process (Policy TX.02.05.00.03 Treatment Review of Medication.)

The "Use of Psychotropic Medication" Policy covers various aspects of psychotropic medication administration including requirements associated with informed consent, emergency medication, medication refusals, and medication reviews.

Chester's "Special Observation" Procedure describes the various levels of observation to promote a safe environment. When staff observe "overt or covert signs of individual suicidal, self-injurious or self-destructive behavior" they are to notify nursing and supervisory staff. Action is to be taken to prevent the self-injurious behavior including providing medical attention or a Code Blue for assistance. A physician can order the recipient to be placed in a safe and secure room restricted to wearing shorts and being provided with special blankets, a secure mattress and a security bed if needed. An assessment is completed and 1:1 observation is provided including when the recipient is eating and showering. A psychiatrist must order the discontinuation of special observation for self injurious behavior after completing a reassessment and a gradual release and access to clothing and personal items. When recipients are on 1:1 observation for more than 2 weeks, a Clinical Review Group is to consider the recipient's treatment. Special observation can also be used when a recipient "…is unwittingly provoking others to assault him," and as part of water intoxication protocol. The Center uses a Personal Safety Plan to survey a recipient prone to self-injury on possible triggers, and calming strategies to help deflect and respond to a crisis.

A policy entitled, Conducting Nursing Assessments, describes the nursing assessment process at admission and thereafter. The policy dictates that "Reassessment to determine the patient's response to care is ongoing and reflected in the nursing progress notes. It will be summarized weekly the first three weeks following admission and monthly thereafter or whenever clinical conditions have significantly changed…."

A "Treatment Plan" Policy and Procedure requires that a recipient's treatment team meet every 30 days and document assessment results, recipient needs, including medical needs and suicidal history, recipient strengths, diagnoses, medication plans, behavioral needs, treatment goals, criteria for separation, fitness, and continued need for mental health services. The medication section of the treatment plan is to include current psychiatric medication, expected outcome, the recipient's response to the medication, medication risks and benefits, any drug reduction plan and medication side effects.

Chester's Patient Handbook emphasizes the recovery process and references rights associated with adequate/humane care, rights restrictions, and the complaint process. Medical services are mentioned and state that medical needs will be reviewed and a physician and nurse are on duty 24 hours per day. With regard to pain management and injuries, the handbook states that nursing staff will evaluate pain using a rating scale and any needed treatment must be ordered by a physician. The treatment plan section states that a review meeting is held each month to assist the recipient in meeting individual treatment goals. Recipients can talk with the treatment team about any treatment questions.

The "Patient Rights" Procedure includes the right to adequate care and services pursuant to an individual treatment plan. The rights restriction process is described.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states that:

> *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 Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.*

The same Code Section addresses psychotropic medication as follows:

> *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. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a*

reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. … A qualified professional shall be responsible for overseeing the implementation of such plan. When rights are restricted the Code requires the following as per Section 2-201:

Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:

(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian….

The Illinois Administrative Code (59 Ill. Admin. Code 112.90) makes provisions for the administration of psychotropic medication in state-operated facilities. Accordingly, the Code requires:

No psychotropic medication or electroconvulsive therapy (ECT) shall be prescribed for a recipient unless examinations have been conducted in accordance with Section 112.30. The prescribing physician shall conduct the examinations personally, or shall review the record of the examinations. The prescribing physician shall record, sign, and date (with time) the prescription. The prescribing physician shall also document in the recipient's clinical record any appropriate clinical information….

With regard to psychotropic medication on an emergency basis, the requirements of subsection (a)(1) need not be met when the prescribing physician has determined by personal observation or from information supplied by another clinician with thorough knowledge of the recipient's current clinical condition that the recipient is in need of immediate medication in order to prevent the recipient from causing serious and imminent physical harm to self or others….

Prior to prescribing psychotropic medications or ECT in non-emergency situations, a physician shall ascertain and document whether the recipient is capable of giving informed consent…. The recipient shall be asked if he/she agrees to receive the proposed treatment. If the recipient does not object, informed written consent shall be obtained from the recipient's guardian or substitute decision maker and shall be documented in the recipient's medical record. If the recipient has no guardian or substitute decision maker or if the guardian or substitute decision maker does not provide such informed written consent, any treatment must proceed in accordance with subsection (c) (Refusal of Treatment)….

If the court grants the petition for involuntary treatment pursuant to Section 2-107.1 of the Code, the recipient may be administered treatment over his/her refusal (or the guardian's or substitute decision maker's refusal if the recipient was legally incompetent but did not object) within the constraints and for the duration of the court order…..

This same Section of the Administrative Code requires certain levels of monitoring for the continued administration of psychotropic medication:

> *The attending physician shall examine and document the status of the recipient's condition in the recipient's clinical record as often as the recipient's clinical condition warrants but no less often than every 30 calendar days. Documentation of the rationale for treatment, including type, dosage or frequency of the proposed treatment as applicable, shall be included. Beneficial effects and significant side effects as well as their treatment and/or management or the absence of treatment and/or management shall also be noted…..Facility staff shall document in the recipient's clinical record additional clinical information such as assessments, evaluations or laboratory results as they become available…..When a recipient at a State-operated mental health facility has been receiving psychotropic medications and/or ECT 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 panel shall consist of representatives from at least two of the following clinical disciplines: psychiatry, medicine, clinical pharmacy and nursing. At least one panel member shall be a physician with expertise in the use of psychotropic medication (for example, psychiatrist or behavioral neurologist)….At least 7 days prior to the date of the treatment review panel meeting, the recipient, guardian or substitute decision maker, if any, and any person designated under Section 2-200(b) of the Mental Health and Developmental Disabilities Code shall be given written notification of the time and place of the treatment review panel meeting. The notice shall also advise the recipient of his/her right to designate some person to attend the meeting and assist the recipient in accordance with Section 2-107.2 of the Mental Health and Developmental Disabilities Code…. The panel shall provide a recommendation concerning the suitability of continued treatment.*

CONCLUSIONS

The complaints allege that a recipient's elbow injury was not treated properly, that his rights were inappropriately restricted and that the facility did not honor the recipient's right to participate in treatment planning. Specifically, the recipient's elbow injury resulted in a large fluid-filled sac protruding from his elbow for which he reportedly received no treatment, other than Tylenol, and no drainage. The recipient was reportedly placed on 1:1 staff supervision for physical aggression but staff incorrectly referenced his being on suicide watch instead which resulted in his belongings being removed. Finally, the complaint stated that the recipient was facing a medication reduction over his objection, indicating that he believes he is on the most therapeutic dose.

With regard to the elbow injury, the Mental Health Code and Chester policies require adequate care and treatment. Documentation indicated that the recipient's elbow was x-rayed, routinely examined by nursing staff, examined by two different physicians, and addressed with medication. The HRA did find that the elbow issue was mentioned in the recipient's treatment plan but there were no related goals/objectives.

The Mental Health Code requires services to be provided in the least restrictive environment and the Center's observation policy describes the process and conditions associated with suicide

observation, including the removal of personal belongings. The HRA found that the recipient was placed on observation for physical aggression on 01-04-13, 1:1 suicide observation on 01-17-13 which was reduced to frequent observation with clothing and room being returned on 01-25-13 and then in seclusion for aggression on 01-29-13. The 1:1 suicide observation was specifically ordered by the psychiatrist based on the recipient's medication refusal, lack of interaction with the psychiatrist, prior history of a suicide attempt at Chester after refusing a medication and a prior history of a suicide attempt while in jail resulting in an injury. All incidents and rationale for the restrictions were clearly documented. The suicide precaution, including the removal of belongings, was clinically justified by the psychiatrist with reviews being done and the restriction reduced within policy dictated time frames. The HRA also found restriction of rights notices for the removal of personal property due to suicide risk and for the use of seclusion due to aggressive behavior.

The Mental Health Code and the Chester rights policy requires recipient participation in treatment planning and recipient consent for medication or medication changes. The complaint indicated concern about a possible reduction of a particular medication which was reflected in the recipient's initial admission treatment plan. However, according to the January and May treatment plans, medications appear to be constant and neither treatment plan mentions a possible medication reduction. It appears that over time medications may have been increased. The recipient participated in two of the three treatment plan meetings reviewed by the HRA.

Based on its findings, the HRA does not substantiate the allegations but does take this opportunity to offer the following suggestions:

1. Although there are progress and treatment plan notes related to the recipient's elbow injury which appeared to be a problem for several weeks, there were no treatment plan goals or objectives included to address the situation. The HRA suggests that medical issues be addressed in the treatment plan through treatment planning goals and objectives.
2. Continue efforts to involve recipients in treatment planning, including any discussions regarding medication changes or reductions. If a reduction for which a recipient has concerns is being considered, provide ample education and reassurance.
3. The HRA found restriction notices for the removal of property and the use of seclusion for this recipient; however, there was no restriction notice for the use of 1:1 observation. Because this type of observation represents a more restrictive form of treatment, the HRA encourages the use of restriction notices when 1:1 supervision is ordered.

1. recipients.