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Egyptian Regional Human Rights Authority
Report of Findings
Chester Mental Health Center
Case #13-110-9026

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 emergency treatment protocol isn't being followed when staff use medication as a first measure. A recipient was given 2 forced injections without an adequate reason.**

2. **Staff on midnight shift refuse to get hygiene items out for recipients to shower in the morning.**

3. **Recipients aren't allowed to use the restroom as needed.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100 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, the community bathrooms nearest to the area where patient counts are done are not available for 45 minutes to an hour per day after count and recipients must seek other restrooms. It was also reported that night staff will not pull together soap and hygiene supplies for 6:30 a.m. showers and morning staff are immediately immersed with breakfast when they arrive; a recipient wants to take his shower before breakfast but he cannot access needed supplies. Also, staff are to attempt to deescalate a recipient's behavior by talking as per the recipient's crisis plan; however, the complaint states that staff go straight for medications when there is a behavioral emergency. The recipient reported 2 incidents of forced medication without adequate reason in March 2013.

Staff Interviews

In e-mail communication with a recipient's therapist, the HRA was informed that the recipient was given two intramuscular injections on 03-13-13; Fluphenazine 5 mg at 1330 for aggression, and, Lorazepam 2mg at 1345 for agitation. The therapist indicated that he could not interview the recipient, "he was in restraints, threatening and spitting at staff." The HRA questioned why the second medication was given so soon after the first. The therapist responded that he spoke with the physicians who reported that "…the plan was to use the less restrictive measure to calm [the recipient]. Very shortly after the injection, he became a threat to harm himself and others. At that time [the physician] requested another injection. [The recipient] had removed his clothing and started throwing them out of his room at staff. He was threatening to eat the button off his clothes. He was threatening to attack staff. He did not go into restraints at that time, so there was some success. He still remains agitated and threatening." The internal human rights committee then met with the recipient who reportedly confirmed that he was threatening staff on 03-21-13. He also reported that a staff person teased him about having a bolted down bed which was reported to the Office of Inspector General as mental abuse.

In correspondence with the facility nursing director, the HRA was informed that she contacted unit staff regarding arrangements pertaining to hygiene supplies and access to community restrooms. She reported that recipients typically do not shower prior to going to breakfast because breakfast is served early, around 7 a.m. although they can use the restroom before eating breakfast. She reported that hygiene supplies are provided when recipients return from the dining room. She also indicated that community bathrooms are only inaccessible for a short period of time needed to take a count of recipients - approximately 5 minutes and not 45 minutes to an hour.

Record Review

With consent, the HRA team examined the record of the recipient who was administered emergency medication. The recipient's initial treatment plan of 09-28-12 documented that the recipient was admitted to the facility from another state-operated facility on 09-27-12 after becoming aggressive, self-injurious and exhibiting "unmanageable behaviors." The recipient has a history of state-operated placements. His diagnoses include Bipolar Disorder with psychotic features, a mild cognitive impairment and several medical conditions. His medication at the time of admission were as follows: Olanzapine for manic symptoms and psychosis; Gabopentin for mood lability; and Lorazepam and Diazepam for anxiety and agitation. His emergency treatment preferences included, 1) Emergency Medication and 2) Restraint. The plan stated that "seclusion is not an option due to the diagnosis of Intellectual Disability." Treatment goals included adaptive social functioning free from self-injurious behaviors, decreased aggression to others and free of Bipolar symptoms. Contained within the goals are treatment approaches which included meeting with the therapist 3 times weekly, training on replacement behaviors, reinforcers for adaptive behaviors, and medication administration/monitoring. For a behavioral emergency, staff were to intervene and implement appropriate emergency interventions, ensuring that to the extent possible, the recipient's emergency treatment preferences were honored as per the treatment plan. The recipient was present and signed the treatment plan although he did not indicate whether or not he agreed with it.

According to infirmary notes, shortly after admission, the recipient was sent to the infirmary due to complaints of wrist pain resulting from an altercation with a peer at the prior state-operated facility. While in the infirmary, he was placed on 1:1 suicide observation and self-injurious behavior after threats of self harm; PRN (as needed) medication was administered by mouth. Later, the same day, the recipient was placed in a physical hold and then a 4 point restraint after attempts to harm self and others; he was released from the restraints approximately 1 ½ hours later and returned to 1:1 observation in the quiet room of the infirmary.

Progress notes surrounding the March incidents involving the administration of medication were reviewed. On 03-13-13 at 13:30, the "Pt. became agitated - yelling, requiring frequent redirection by staff - upset because he did not get to go to game room. Ordered Prolixin 5 mg IM [intra muscularly] as contingency medication. Pt. cooperated with injection given …w/o incident." Fifteen minutes later at 13:45, "Lorazepam 2mg IM given as contingency medication due to increasingly agitated behavior…w/o incident." On 03-14-13, there is a psychologist's progress note that stated the recipient had threatened to swallow buttons on the previous evening if not able to go to a particular area. The note mentioned that the recipient had recently swallowed a pencil and attempted to swallow a comb; thus he had been placed on a restricted level, including a room with a bolted bed and no access to personal items. However, his status changed on 03-11-13 to allow him back to his room and access to a desk, chair and clothes without buttons but he was not allowed access to smaller personal items. He was also placed on supervised phone use. The arrangements were discussed with the recipient on 03-14-13 after which he became very upset, making verbal threats and slamming doors. On 03-14-13 at 12:20 the physician was contacted about "contingency medication" and the recipient was offered an accepted a PRN medication by mouth at 12:25. At 13:05 on 03-14-13, he was placed in a physical hold and then a 4 point restraint after attacking staff causing injuries. Notes stated that the patient was extremely agitated while in restraints and singing at the top of his lungs; at 13:25, Prolixin 5mg and Lorazepam injections were given. Another administration of Prolixin and Lorazepam injections were given on 03-20-13 after extreme agitation and hitting at staff. A similar order by mouth was offered and accepted by the recipient on 03-21-13 for agitation. A progress note by the psychologist on 03-22-13 indicated that the recipient had been upset with her as she was not able to see any patients due to laryngitis and the recipient had threatened, on 03-21-13, to choke the psychologist and break her neck if she appeared on the unit. Medication was given on 03-22-13 after the recipient became aggressive in the dining room, flipped over a chair and acted like he was going to throw the chair at staff; according to the notes, the recipient was offered and accepted PRN (as needed) medications by mouth on this occasion. Later on the same day, he was placed in restraints for swinging at staff with a closed fist and threatening to throw a foot stool at staff. The HRA observed a later note in the progress notes, dated 05-13-13, that stated the "Patient has done really well since transfer to Unit B. He has not required any FLR [full leather restraints] or contingency medication."

Psychologist monthly progress notes were also examined and provide additional details regarding the recipient's behaviors. According to the monthly notes for March 2013, the recipient required restraints twice: on 03-14-13 when he threatened to swallow buttons and became severely agitated when clothing with buttons were removed from his room which escalated into physical aggression toward staff; and, on 03-22-13, when the recipient was discovered removing buttons from clothes in a laundry hamper after which he became agitated

and then aggressive toward staff. The notes also documented 3 instances in which the recipient became aggressive but redirection was effective and restraints were not needed: on 03-20-13 when he went into a fighting stance with the unit director; 03-21-13 when the recipient threatened to choke and break the neck of the psychologist; and, earlier on 03-22-13 when he threatened to throw a chair. Also during the month of March, the psychologist's report documented 18 behavior reports that included such behavior as being non-cooperative with medication pass, being loud/disruptive, making verbal threats, urinating in his room, smearing feces on the wall in his room, stealing food from a peer's food tray, etc. The notes make reference to a telephone restriction and indicated that he called the Office of Inspector General pretending to be a peer reporting a broken finger. The psychologist also documented that "A Recovery Plan has been developed with [the recipient's input, and [the recipient] has the opportunity to earn the discontinuation of current restrictions as his behavior improves. [The recipient] meets daily with this writer and is very cooperative during individual sessions (i.e. identifies positive goals, verbally expresses intent to improve, etc) with emphasis upon his stated long-term goal (i.e. "transfer") and the steps required to reach that goal (i.e. "daily behaviors"). [The recipient] clearly understands these concepts and expresses himself articulately regarding these matters. However, his daily behavior on the module is inconsistent with his stated intention, and he continues on red level at this time."

Psychologist monthly progress notes for prior months were also reviewed. It appeared that there was a gradually increase in monthly behaviors over the course of the prior 3 months; however, none of the behaviors listed in the reports from December 2012 through February 2013 required the use of restraints or emergency medications. There was documentation of making fake "code red" calls to the facility control room, filing a false report to OIG claiming to be a peer and attempting to steal a peer's phone card numbers, placing a large Avon order using a peer's phone card, removing a telephone cord, and flipping a chair.

The HRA examined 6 restriction of rights notices for the month of March 2013. The first one documented that on 03-01-13 at 1805-1806 the recipient was placed in a physical hold for "threatening staff to fight - swang & hit arm - PH [physical hold] for safety of all." On 03-14-13 at 1235 the recipient was placed in a physical hold as per the restriction notice that stated the "Recipient stripped & was naked & highly agitated attacked staff." The notice stated that the recipient's individual emergency treatment preference was utilized and a PRN medication was given. It did not indicate that the recipient refused the PRN medication. On the same day at 1240, the recipient was placed in restraint for the same reason - for being highly agitated and attacking staff. A restriction notice regarding at 03-22-13 incident documented that at 1305 the recipient was placed in a physical hold for "charging staff & swang at staff. Picked up foot stool & trying to harm staff." And then on the same day, five minutes later at 1310, another restriction was issued when the recipient was placed in restraint cuffs: "cont to struggle & fight with staff making transport difficult. Cuffs applied for safe transport to restraint room." Then, on the same date at 1315, another restriction notice stated that the recipient was placed in restraints when he continued "…to fight and struggle with staff. Refused to calm down."

A restriction of rights notice dated 04-05-13 indicated that the recipient was restricted from having clothes and personal property in room for safety "…due to threat of self-injurious

behavior….may now have desk and chair in room." The restriction was to be in place from 04-05-13 to 05-05-13.

The HRA examined no restriction of rights notices specific to the administration of emergency medication even though IM injections (versus medication by mouth) were given on 03-13-13, on 03-14-13 at 13:30 and on 03-20-13.

A Utilization Review Form was completed on 06-10-13 which documented that the recipient was moved to a different unit on 04-19-13 and, since the move, the recipient "…has not been a behavior problem."

Medication administration records indicate that the recipient generally accepts his medications as prescribed, that he periodically requests Acetaminophen, and that he received contingency medications as indicated in progress notes, IM medication on the 13th at 1330 and 1345, by mouth and IM on the 14th and IM on the 20th. A note on the medication administration record for March 20th specifically documented the terms, "emergency enforced."

An Office of the Inspector General (OIG) Report dated 05-21-13 indicated that an allegation of abuse was reported on 03-14-13 stating that on 03-13-13, "unnamed staff members manhandled [the recipient] while forcing him to take a PRN injection." A facility investigator interviewed the recipient who stated he was forced to take a PRN medication that he didn't like but "…he never mentioned anything about being manhandled or abused. A review of the facility records revealed that [the recipient] had been very agitated and yelled at staff members because he was not allowed to go to the game room [The physician] spoke with the recipient and ordered a PRN for his behavior. The facility's progress notes also revealed that the injection was given without incident. The video recording showed several staff members assisting Registered Nurse…with the compliance of the medication. The video also revealed that [the recipient] spoke with several STA [security therapy aides] after the injection and showed no signs of duress." The allegation of abuse was considered to be unfounded by the OIG.

<u>Policy Review</u>
The HRA team examined Chester policies and procedures pertinent to the complaint. The "Use of Psychotropic Medication" procedure provides operational guidelines for administering psychotropic medication including medication evaluations, the informed consent process and medication reviews. Included in the procedure is a section on emergency medication which states that "The physician or RN initiating the use of emergency medication must document in the progress note that due consideration was given to the patient's treatment preference regarding emergency medication and must include justification for deviation from the patient's preference."

Chester's Treatment Plan procedure stated that "During the collection of information regarding behaviors, the patient will engage in identifying early interventions that may help minimize the need for restraint and/or seclusion. The team will identify early indicators of escalating behaviors as well as techniques, methods, or tools that might help the patient manage his thoughts, feelings and behavior. The patient, guardian and family may assist in this process. In the event that the above strategies fail and emergency intervention is necessary, patients will be informed about the DHS/DMH policy about seclusion and restraint and provided with education

about the circumstances under which seclusion and restraint may be necessary. Patients will be queried regarding preference for restraint, seclusion or emergency medication should it be necessary to implement such interventions. If a patient is unable to articulate choices and preferences at the time of this assessment, efforts to obtain this information should be reviewed monthly until obtained. These preferences should be reviewed monthly to ensure that the preferences are current." This same procedure requires that the treatment plan include information on current psychiatric medication, intended outcome and response to the mediation, risk/benefit information, a drug reduction plan and side effects.

The facility's "Patient Rights" procedure includes the right to "…adequate and humane care and services in the least restrictive environment, pursuant to an individual treatment plan." The Rights information also states that patients who live on units that have private bathrooms in their patient rooms have the right to full access to their individual sinks and toilets unless restricted for clinical reasons. The right to refuse medication is also listed along with a description of the process for restricting rights, including the issuance of a restriction notice when rights are restricted during an emergency.

Chester's Patient Guide states that recipients are to shower daily and wear fresh clothing with showers being mandatory twice each week. A section specifically entitled, "Soap, Towels, and Showers" states the following: When you are assigned a room on the module, you can ask the STA [Security Therapy Aide] on duty for a face cloth and soap. Larger towels are available for daily showers. You will be allowed to keep one wash cloth and one bath towel in your room. The shower stalls are available for use on a daily basis. Security staff on duty will show you where these items are located and how to get them. All patients are expected to shower twice a week unless special circumstances prevail." The Guide also includes a section on recipient rights, including the right "…to adequate and humane care and services in the least restrictive environment and to an individual service plan…." As well as the right to refuse services "…except when necessary to prevent you from causing harm to yourself or others."

MANDATES

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

> *(a) 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….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.*

> *a-5) 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 Mental Health Code (405 ILCS 5/2-107) also addresses the right to refuse medication as follows:

> *An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. 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.*

If emergency medication is administered, the Mental Health Code (405 ILCS 5/2-201) dictates that a restriction of rights notice be issued:

> *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) also directs state-operated Department of Human Services facilities to follow the following regulations:

> *a) Evaluation*
>
> *1) 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.*
>
> *2) 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….*
>
> *c) Refusal of Treatment*

A recipient's refusal to receive psychotropic medication or ECT does not in itself constitute an emergency. Such refusal, as documented in the clinical record, shall be honored except in the following circumstances:

1) Emergencies

In an emergency, when treatment is necessary to prevent a recipient from causing serious and imminent physical harm to self or others.

A) In such an emergency, a member of the treatment/habilitation team shall document in the recipient's clinical record that the staff have explored alternative treatment options to contain the emergency. The documentation shall include a written explanation of the reasons why alternative treatments are not appropriate.

B) For administration of psychotropic medications the prescribing physician or a nurse in consultation with a physician shall document his/her determination that an emergency exists based on a personal examination of the individual. Administration of the medication shall be accompanied by a physician's order.

C) In prescribing psychotropic medications on an emergency basis the prescribing physician shall examine the recipient and document his/her determination of the initial emergency and response, including the circumstances leading up to the need for emergency treatment, in the recipient's clinical record as soon as possible, but within 24 hours. Psychotropic medication may not be continued unless the need for such medication is redetermined at least every 24 hours and the circumstances demonstrating that need are set forth in the recipient's clinical record. A redetermination is based on a personal examination of the recipient by a physician or a nurse with the consultation of a physician.

D) Treatment shall not be administered over a recipient's refusal under Section 2-107 of the Mental Health and Developmental Disabilities Code for a period in excess of 72 hours, excluding Saturdays, Sundays and holidays, unless the treating physician with the support of the treatment/habilitation team files a petition for a court order under Section 2-107.1 of the Code and the treatment continues to be necessary in order to prevent the recipient from causing serious and imminent physical harm to self or others. If no such petition is filed, treatment must be discontinued.

E) A restriction of rights form shall be completed for each administration of emergency treatment.

F) ECT may be administered over a patient's refusal only with a court order and prior written physician's order or in emergency situations as defined in Section 2-107 of the Code.

G) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the use of emergency forced medication is permitted under Section 2-107(a) of the Mental Health and Developmental Disabilities Code [405 ILCS 5/2-200(d)].

Concurrently, the facility shall ask the recipient which form of intervention he/she would prefer if any of these circumstances arise. The recipient's preference shall be documented in the clinical record and communicated by the facility to the recipient's guardian or substitute decision maker, if any. If any such circumstances arise, the facility shall give

due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive.

H) Under no circumstances may long-acting psychotropic medications be administered under Section 2-107 of the Code.

CONCLUSIONS

With regard to the complaint that a recipient's emergency treatment protocol was not being followed when staff use medication as a first measure and that a recipient was given 2 forced injections without an adequate reason, the HRA found that two occasions when forced medication was administered that did not meet the Mental Health Code's standard for emergency medication as per facility documentation. On 03-13-13, the recipient was described as being "…agitated - yelling, requiring frequent redirection by staff…." when emergency medication was administered. On 03-14-13 after he was already placed in restraints for attacking staff, the recipient was administered forced medication because "…patient was extremely agitated while in restraints and singing at the top of his lungs." Neither instance meets the Code's requirement that the emergency medication was necessary to prevent "serious and imminent physical harm to the recipient or other." The recipient's emergency treatment preference was listed as medication first and restraints second; however, physical holds and restraints were sometimes used instead of medications. The HRA also found that the recipient's treatment plan included varied approaches to addressing the recipient's behavior besides just medication and these approaches appeared to be used as per treatment plan and psychologist progress notes. In addition, Chester policy emphasizes less restrictive behavioral interventions consistent with Mental Health Code provisions. Besides the inadequate justification for emergency medications on two occasions, the HRA also found that the record lacked restriction of rights notices in three instances when emergency medications were administered. The facility appeared to use medication as an emergency intervention against the recipient's wishes on March 13th when medication was given by injection versus by mouth and an OIG report indicated that several staff assisted with the administration, on March 14th when medication was administered by injection at 13:30 and on March 20 when the medication was administered by injection and the medication administration record documented that they were "enforced meds." The Mental Health Code and Chester policies require the issuance of restriction of rights notices when administering emergency medications. **Therefore, the HRA substantiates a violation of rights associated with emergency treatment protocol and issues the following recommendation:**

1. **Follow the Mental Health Code and administer emergency medication over a recipient's objection only when the medication is needed to prevent serious and imminent physical harm to self or others. Document accordingly. Remind staff of this requirement.**

2. **Follow the Mental Health Code and Chester policy and issue a restriction of rights notice when administering emergency medication over a recipient's objection. Remind staff of this requirement.**

The HRA also offers the following suggestions:

1. Ensure that emergency treatment preferences are reviewed during each treatment plan review as per Chester policy; recipients may become dissatisfied or may have misunderstood their originally stated preferences and may desire a preference change.

2. The OIG report indicated that the facility investigator interviewed the recipient but, "…he never mentioned anything about being manhandled or abused." The HRA strongly suggests that when the facility investigator approaches a recipient about an abuse report, the investigator thoroughly questions the recipient about the allegation.

3. The Code makes no provision for "contingency meds" and the use of this term is confusing for staff and recipients alike. Recipients/guardians provide consent for physician ordered medications but maintain the right to refuse that medication. When behaviors are exhibited and medication is considered as a means to address those behaviors, the recipient must either consent to the medication or the facility can administer the medication over the recipient's objection, as emergency medication, if the Code's criteria for emergency medication are met. The HRA strongly urges the facility to discontinue the use of the term, "contingency meds."

With regard to the allegations related to the lack of hygiene supplies for early morning showers or the lack of accessibility of restrooms during recipient checks, the HRA received staff confirmation that supplies are provided after breakfast community restrooms are closed during recipient counts. The facility reported that hygiene supplies are provided after breakfast due to the early hour that breakfast is served and that the supplies are upon recipients' return from the dining room. The facility indicated that units that have community versus individual restrooms close the community restrooms during recipient counts but that the time frame involved is 5 minutes versus 45 minutes to an hour as per staff reports. Chester's Patient Guide indicates that hygiene supplies be available via security therapy aides and the rights section guarantees access to toilets with some units having private toilets in recipient rooms and other units having shared toilet facilities. The Mental Health Code guarantees the right to adequate and humane care and services. Although hygiene supplies are provided after breakfast versus before breakfast, the HRA does not necessarily find this a rights violation it does not that the Mental Health Code makes mention of recipient preferences. The HRA is unable to confirm or deny allegations related to access to the community restroom but it does note that in order to account for the presence of all recipients, it might be necessary to close the restroom for a short period of time noting that the term "counts" may sound institutional and akin to correctional facilities. Based on its findings, the HRA does not substantiate rights violations related to accessibility to hygiene supplies or the community restrooms but it does offer the following suggestions:

1. Review recipient access to hygiene supplies, particularly for early morning showers for recipients who may have such a preference.

2. Review the accessibility of restroom facilities particularly on units that do not have toilets in recipient rooms.

3. Consider alternative means and terms to account for service recipients.