FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
14-110-9013
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 visits were inappropriately restricted.**
2. **A recipient's therapist breached confidentiality.**
3. **A recipient received an inappropriate administration of medication.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2); the Confidentiality Act (740 ILCS 110) and the Code of Federal Regulations (42 CFR 482 and 45 CFR 164).

To investigate the allegations, the HRA Investigation Team (team), consisting of two members and the HRA Coordinator conducted a site visit at the facility. During the visit, the team spoke with the recipient whose rights were alleged to have been violated and interviewed staff. With the recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility policies relevant to the complaints were also reviewed.

Allegation 1. A recipient's visits were inappropriately restricted

I. Interviews:

A. Recipient: The recipient informed the team that he has high blood pressure and sometime in November, 2013 staff "tried to treat it" with Ativan because they said he was agitated. He stated that staff told him if he did not take the Ativan, he would not be allowed to go on his visit and also that if he did not take the pill by mouth, they would make him take it by force by holding him down and giving him a shot. The recipient stated that for these reasons, he agreed to take the Ativan but he was still not allowed to visit with his girlfriend. The recipient stated that his preferred emergency treatment protocol is seclusion first, then restraints and then medication. [The medication portion of this allegation is addressed under allegation 3 below.]

Another incident occurred around the 13th of January when his therapist "got mad" because he would not listen to her in a treatment meeting and refused to talk to her therefore, she cancelled his visit. He also stated that his therapist wanted him to sign a release giving permission for her to speak with his girlfriend about why the visit was terminated but he refused to sign the release so he was not allowed to visit with his girlfriend.

B. Girlfriend: The HRA spoke with the recipient's girlfriend by telephone with written permission from the recipient. His girlfriend informed the HRA that she was at Chester to visit with the recipient from January 11-13, 2014. She stated that on January 12th during a visit her and the recipient argued but denied that they were loud. STAs (security therapy aides) who were monitoring the room said that they would terminate their visit if he did not calm down. Shortly after that, they called the recipient's escort to return him to his unit before they were finished with their visit. When they informed the STA that they were not done visiting, the STA stated "I'm not going to come back and forth" and terminated the visit and escorted the recipient back to his unit. On the second day, she came for her visit and was told that their visit had been denied because the recipient would not give permission for his therapist to speak with her. Finally, she stated that on January 13th, their visit was terminated. The reason given was that the recipient threatened to punch the girlfriend in the face. She denied that the recipient made that statement to her.

The recipient's girlfriend also shared concern over the recipient's blood pressure issues. She stated that he has had high blood pressure for 2-3 years. Sometime in late December, after the Christmas holiday, he had a blood pressure spike and was given Ativan and was "in and out of it." She stated that the recipient told her that staff had stated to him that if he did not take it, he would be restrained.

C. Therapist: The HRA later interviewed the recipient's therapist. She stated that the recipient had 2 female friends that came to visit him. During a visit with one of them the STA monitoring the room observed her performing "hand sex" on the recipient and gave them a verbal warning. The recipient "got verbal with her threatening" but the STA did not terminate the visit. The therapist stated that the recipient "won't cooperate with females unless he has something to gain by talking to them." She informed the HRA that he has made derogatory statements to her such as "women should be put in their place in the bedroom and kitchen." She said that the recipient is at Chester to attain fitness, but he believes he is not here for fitness but for anger management from a child protective agency. The HRA asked what treatment usually occurs when someone is admitted as UST (unfit to stand trial). The therapist stated that the recipient takes the fitness test initially and then they are started in class to work on the portions that they do not understand. This recipient knew 100% from the beginning. She is of the opinion that all of his issues are about him being "in control" and he has made the statement that "Chester won't tell him when he is ready for Court." She also informed the HRA that he was taken out of fitness class at the request of other patients because he kept talking about his case rather than the court process. Specifically he brought up spanking a child and upset other recipients. When asked if she requested a release of information to speak with the recipient's girlfriend, she denied doing so. She also denied restricting his visits and stated that she didn't think visits could be restricted but directed the HRA to check with the STAs as they would know more about that.

D. STAs: The HRA interviewed a STA who was to have been supervising the visits during the timeframe of the incidents. The first STA denied being at work that day but gave the HRA the name of another STA who would have been. The HRA interviewed that STA. He stated that to the best of his recollection, the recipient made threatening comments and was cussing at his girlfriend; however he was allowed to finish the entire visit. He did not remember subsequent visits being terminated but said that they could possibly be restricted if a recipient was acting aggressively on the unit prior to the visit or making threatening statements. He stated that visits are not regularly restricted as that is something that recipients look forward to and stated that usually recipients are more cooperative at that time because they want to visit with family and friends so they do not have many behavioral issues around visiting times.

II. Clinical Chart Review:

A…Treatment Plan Reviews (TPRs): The 1/13/14 TPR mentioned under "extent to which benefiting from treatment" section that he had stabilized and shown significant improvement and has regular visits with friends. It was also noted that during one of his visits "it was reported that he became inappropriate with the female visiting and had to be counseled by security staff about his aggressive behavior. It appears [recipient] has an increase in aggression when in the presence of females."

B...Progress Notes: A 1/13/14 social worker note stated that on 1/12/14 at 3:30 p.m. during a visit with a female visitor, the recipient "began talking very harsh to the visitor. She started to cry; staff intervened and de-escalated the situation. [Recipient] became verbally aggressive a second time and STA-4 had to be called. STA-4 counseled [recipient] about his behavior. No further incidents after that. [Recipient] was overheard saying 'Do you know what that means, that means I'm going to hit you in your [explicit] lip, that's what that means.' [Recipient] will be reviewed by treatment team to review further action." The HRA found nothing further in case notes or treatment plans indicating what further action, if any, was taken and found no restriction of rights forms documenting that visits were restricted.

III...Facility Policies:

A. Patient Rights Policy RI .01.01.02.01 states "…A list of patients' rights as delineated in the Program Directive 02.01.06.010, Prevention of Abuse and/or Neglect of Individuals, is as follows…2. Individuals shall have the right to unimpeded, private, and uncensored communication with persons of his or her choice by mail, telephone calls, and regular visitors. 3. Individuals have the right to visit with whom he designates, including but not limited to, a spouse, a domestic partner (including same sex domestic partner), another family member, or a friend. Individuals have the right to designate a Support Person on the Visitation Rights form (CMHC-349) who can exercise the visitation rights in the event the patient is incapacitated or otherwise unable to do so."

Initial Notification of Restriction of Patient Rights in this same policy states "Non - Emergency Restriction of Rights. A restriction of a patient's rights should be based on clinical assessment of the patient and/or the situation. A Notice Regarding Restricted Rights of Individuals (IL462-

2004M) will be issued to restrict the patient's rights. 2. If any of the patients' rights as described in Section I. of this procedure are restricted then a Restriction of Rights of Individuals (IL462-2004M) will be initiated. This includes when a patient is restrained, secluded and/or subject to a physical hold. 3. The Unit Director or designee will ensure that the initiation of the restriction is reported, discussed, and approved at the Facility Morning meeting. 4.When a Restriction of Rights is implemented and reviewed by the treatment team – emergency or non-emergency they will ensure the restriction form is approved and signed by the Facility Director or designee. When the Restriction of Rights involves mail, access to the patient's room, or telephone, the form IL 462-2004M must be signed by the Facility Director or designee prior to initiation of the restriction..."

Statutes

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

The Code (405 ILCS 5/2-201) requires that "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 the recipient and, if such recipient is a minor or under guardianship, his parent or guardian… The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record."

The Code (405 ILCS 5/2-103) provides that "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility **shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation.** (a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to recipients who reside in Department facilities and who are unable to procure such items. (b) Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. (c) Unimpeded, private and uncensored communication by mail, telephone, and visitation **may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation**, provided that notice of such restriction shall be given to all recipients upon admission. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect…"

Conclusion

The recipient stated his visit was restricted due to not signing a release for his therapist to speak with his girlfriend and another time because he had to take Ativan first, but then was denied visitation anyway. His girlfriend stated that they did get to visit, but it was ended early due to an argument they had and a STA refusing to "go back and forth" to escort the recipient. The case notes corroborate that a STA was called after the recipient became verbally aggressive for a second time but does not mention terminating the visit, only that the recipient was "counseled with." The STA also reported that the visit was not terminated and neither were subsequent visits. The HRA found no documentation to the contrary therefore, the allegation is **unsubstantiated.**

Allegation 2. A recipient's therapist breached confidentiality.

I...Interviews:

A..Recipient: The recipient informed the HRA that his therapist talks about his case in specifics during UST classes and in the halls where other patients can hear. He requested to change therapists but was told by the unit director he could not. He did not have the names of specific people that he allegedly overhead his therapist divulge confidential information to, just that it was mostly in UST classes.

B..Girlfriend: The recipient's girlfriend informed the HRA during a telephone interview, with written consent from the recipient to speak with her, that the recipient's therapist breached confidentiality by "talking about his personal business in front of patients and said he was using Chester to stay out of jail and she was going to find him fit whether he was or not."

C..Therapist: During the interview with the recipient's therapist, she denied discussing any confidential information with other staff in the open where other recipients could hear. She did state that during his fitness class, he would often bring up his personal case and try to discuss that in front of the class rather than focusing on the court process which is the intended topic of discussion in fitness classes. She did say that she occasionally makes references in classes to specific issues that she knows pertains to some recipients in the class but she never points out which recipient it pertains to, just opens the topic for general discussion and does not identify any recipients specifically to which it might pertain.

D. Unit Director: The HRA met briefly with the unit director to ask her about how patients are assigned therapists and if that could be changed. She stated that therapist caseloads are assigned by units. Each unit has a therapist who sees all patients on that particular unit. They try not to change therapists because they would rather have the patients work through disagreements and issues rather than constantly switch therapists in order to avoid dealing with issues. However, there have been times in the past where the treatment team has decided to change therapists under certain circumstances, but those cases are reviewed closely and a determination is made by the entire treatment team.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): TPRs for November, 2013 through February, 2014 were reviewed. None of the reviewed TPRs included statements in the discussion section documenting that the recipient raised the concern of patient-therapist confidentiality. The therapist note in the November TPR stated that the recipient had been cooperative with an evaluation of fitness and noted that he had made significant progress and his symptoms improved with treatment. The December TPR therapist note documented that the recipient "has been less than cooperative with evaluation of fitness. [recipient] scored a 95% on the fitness exam, however he has no desire to work with his attorney…becomes verbally aggressive when he is expected to partake in Fitness Education for Court…has shown improvement behaviorally as long as things go the way he wants. He shows significant increase in aggression (verbally) when he feels challenged." The January TPR documented in the discussion section that the recipient "is very inappropriate toward his therapist. He verbally attacks anything that she has to input at his monthly reviews. [recipient] has a history of inappropriate behavior toward females including physical and aggression." Some of the therapist notes in this TPR include "[recipient] refuses to discuss court procedures as it pertains to him…scored a 95% on the fitness exam, however he has no desire to work with his attorney. He stated the answers were on the bulletin board and that he won't attend Fitness Classes because he has a right to do what he wants…had one episode of aggression. Started on medication, no problems since unless he feels things aren't going his way…denies any wrong doing." The psychiatrist noted "he is on court enforced meds. Still reluctant to accept. Behaviorally problematic and tends to argue and disagree. He is hostile, belligerent, and did not want to continue interview and stay in TPR. He seems to avoid help from therapist." The February TPR documented in the discussion section that the recipient "appears to have more verbal altercations with females versus males. He is described as disrespectful and verbally inappropriate with female staff. Stating 'they think they can tell me what to do.' [recipient] is capable of working with his attorney and he is familiar with court terminology and process therefore the treatment team agree he is fit to stand trial." The therapist notes stated the recipient had "scored a passing grade on the fitness exam…He is capable of cooperating with his attorney. [recipient] may or may not cooperate if he feels the hearing is not going in his favor."

B. Progress Notes: Case notes from October, 2013 through March, 2014 were reviewed. No documentation indicated that the recipient had ever requested a change of therapist or expressed concerns to other staff members about his therapist breaching confidentiality.

III...Facility Policies:

The Mental Health and Developmental Disabilities Confidentiality Act Policy 03.01.04.12 directs staff to "Ensure we adhere to all of the guidelines and procedures in the Mental Health and Developmental Disability Act."

The Code of Ethics Policy 05.00.00.01 lists the following "Specific Ethical Principles to which Chester Employees are Committed: Every employee of Chester Mental Health Center shall be expected to commit to the following principles: To comply with applicable laws of the United States, the State of Illinois, and the local jurisdiction…To comply with Policy and Procedure Directives of the Department of Human Services…To endorse discipline-specific Codes of

Ethics…To conduct all personal and professional activities with honesty, integrity, respect, fairness, and good faith in a manner that will reflect positively on the individual, his/her profession, and the facility…"

Statutes

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/3) states in the section entitled, "Records and communications; personal notes of therapist; psychological test material" that "(a) All records and communications shall be confidential and shall not be disclosed except as provided in this Act..."

The Act (740 ILCS 110/9) further states in Therapist's Disclosure Without Consent that "In the course of providing services and after the conclusion of the provision of services, including for the purposes of treatment and care coordination, a therapist, integrated health system, or member of an interdisciplinary team may use, disclose, or re-disclose a record or communications **without consent** to: (1) the therapist's supervisor, a consulting therapist, members of a staff team participating in the provision of services, a record custodian, a business associate, an integrated health system, a member of an interdisciplinary team, or a person acting under the supervision and control of the therapist; (2) persons conducting a peer review of the services being provided…In the course of providing services, a therapist, integrated health system, or member of an interdisciplinary team may disclose a record or communications without consent to any department, agency, institution or facility which has custody of the recipient pursuant to State statute or any court order of commitment. **Information may be disclosed under this Section only to the extent that knowledge of the record or communications is essential to the purpose for which disclosure is made and only after the recipient is informed that such disclosure may be made.** A person to whom disclosure is made under this Section shall not re-disclose any information except as provided in this Act"

The Code of Federal Regulations (45 CFR 164) specific to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) states in section **"164.502 Uses and disclosures of protected health information: General rules** (a) Standard. A covered entity or business associate may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter (1) Covered entities: Permitted uses and disclosures. A covered entity is permitted to use or disclose protected health information as follows: (i) To the individual; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with § 164.506…(2) Covered entities: Required disclosures. A covered entity is required to disclose protected health information: (i) To an individual, when requested under, and required by § 164.524 or § 164.528; and (ii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity's compliance with this subchapter. (3) Business associates: Permitted uses and disclosures. A business associate may use or disclose protected health information only as permitted or required by its business associate contract or other arrangement pursuant to § 164.504 or as required by law. The business associate may not use or disclose protected health information in a manner that would violate the requirements of this subpart, if done by the covered entity, except for the purposes specified under § 164.504(e)(2)(i)(A) or (B) if such uses or disclosures are permitted by its contract or other arrangement…(e)(1) Standard:

Disclosures to business associates. (i) A covered entity may disclose protected health information to a business associate and may allow a business associate to create, receive, maintain, or transmit protected health information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information. A covered entity is not required to obtain such satisfactory assurances from a business associate that is a subcontractor**…" Section 164.506 Uses and disclosures to carry out treatment, payment, or health care operations** states "(a) Standard: Permitted uses and disclosures. Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) through (4) or that are prohibited under § 164.502(a)(5)(i), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart**…"**

Conclusion

The therapist allegedly disclosed confidential information about the recipient in UST classes and hallways where other patients could hear. The therapist admitted that she sometimes makes references in UST classes to specific issues that she knows pertains to some recipients in the class but she never points out which recipient it pertains to, just opens the topic for general discussion and does not identify any recipients specifically. There was no documentation in the case notes or TPRs that showed that there had been any complaints from the recipient or others regarding concern for therapist/patient confidentiality. Therefore, the allegation is **unsubstantiated.** The HRA offers the following suggestion.

1. No policy was found that directly addresses therapist-patient confidentiality. The HRA suggests that a policy be created to address issues such as confidentiality during therapy sessions, when discussing patients with other colleagues, with outside entities and the confidentiality process when the Court is involved.

Allegation 3. Inappropriate administration of medication.

I...Interviews:

A. Recipient: In addition to what is detailed above under the *Allegation 1* section of this report regarding his visits allegedly being restricted if he did not agree to take Ativan, the recipient also informed the HRA about another incident which occurred in early November. The recipient stated that another peer was "following him around antagonizing him." He explained that he walked away but the peer "slapped him anyway." As a result, the recipient stated that he was "placed in seclusion, given helldog [Haldol] and felt like I was in a car and jumped out." He stated he was in seclusion for 4 hours and stated that a staff person told him "if cameras weren't here we would have real fun, we used to beat asses." He could not recall the staff person's name but stated that he reported the incident to the Office of Inspector General (OIG). The HRA checked with the OIG and discovered that there was a complaint filed around this timeframe but it was declared "non-reportable" by the OIG.

The recipient told the HRA that he was previously on "Hydroxy" to treat high blood pressure and stated that he had never been given Ativan for that until he was at Chester. The HRA could not find a medication by that name online but did find Hydralazine, used to treat high blood pressure, that he could have been referring to as well as Hydroxyzine, which is an antihistamine used to treat anxiety, tension and nervousness. He stated that in the past, when he was younger, he had been on Thorazine [antipsychotic medication], Ritalin [central nervous system stimulant], Methylphenidate [central nervous system stimulant], Zoloft [antidepressant] and Lithium [treats manic episodes and depression]. The hospital prior to Chester had "just left him on Zoloft." The recipient stated that at Chester, the doctor put him on Lorazepam by Court order even though he was not refusing medications. He had asked for Zoloft but the doctor would not prescribe that and would not explain why.

II. Clinical Chart Review:

A. Treatment Plan Reviews (TPRs): The 11/19/13 TPR stated in the discussion section that the recipient was on Court enforced medication at that time. Under the *medication plan section* it was noted that the recipient initially refused to consent to medication Olanzapine 10 mg and Lorazepam [Ativan] 2 mg. and again noted he was on "court enforced psychotropics." The psychiatrist noted that he was on court enforced medications but was still reluctant to accept them. The nurse reported that he had been compliant with emergency enforced medication. The *extent to which benefitting from treatment* section noted that the recipient was uncooperative upon admission, but since beginning medication he had stabilized and had shown significant improvement. The 12/17/13 TPR noted the following in the *medication plan section*: "initially he refused to consent-if consents (either verbal or written). Olanzapine 10 mg AM [morning] and HS [night]. Lorazepam 2 mg BID [twice per day] for anxiety, unable to comprehend or cooperate. He is currently on court enforced psychotropics. He did respond but refused to acknowledge…" Under *Response to Medication* it documented that "he has difficulty to accept his UST status. Mental problems and need for meds. He was quite hostile and paranoid became escalated aggressive. Required seclusion to contain his aggression. But quickly recovered and became cooperative" It was also noted that he refused to sign the consent and documented that his emergency intervention preference is 1)seclusion 2) medication and 3) restraints. The psychiatrist noted again that he was on court enforced medications but was still reluctant to accept them while the nurse noted he had been compliant with court enforced medication. The 1/13/14 TPR stated verbatim what the previous TPR had documented. In the *Response to Medication* section, the following was added to this month's TPR "complains of sedation during the day, seems meds could be causing, also weight gain…" The psychiatrist note regarding medication was the same as on the 12/17/13 TPR. The nurse reported that the recipient had been compliant with court enforced medication but added that "patient was placed back on crush and observe."

B…Restriction of Rights: On 11/2/13, a restriction of rights form was completed stating that the recipient "was agitated over the phone and requested a PRN [as needed medication]. No consent obtained. Patient received 1X dose of Ativan 2mg PO [orally]." The form indicated that the individual preference was not utilized because the recipient requested a PRN. On 11/4/13, another restriction of rights form documented that the recipient was given "emergency enforced medication due to psychosis. History of non-compliance and aggression." The form

documented that the individual preference was not utilized because "medication is only choice for long-term help with psychosis." On 11/5/13 a restriction of rights was given for "emergency enforced medication due to psychosis. History of non-compliance and aggression." The individual preference was not utilized because "medication is only choice for long-term help with psychosis." On 11/13/13 a restriction of rights form was completed documenting that court enforced medication was administered "due to psychosis. History of non-compliance and aggression for 90 days." This form also documented that the individual preference was not utilized because "medication is only choice for long-term help with psychosis."

C…Restraint Records: On November 3, 2013 the recipient was placed in restraints for "attack on peer causing harm, then made direct threats to kill peers and staff. Escorted to restraint room." The order for restraint documented that prior to restraint the following interventions were attempted without success: empathetic listening, distraction, verbal support, walk with staff, voluntary time our and reassurance. The documentation showed that the recipient was in restraints for 4 hours (from 11:00 a.m. until 3:00 p.m.) with checks every 15 minutes. The release criteria listed on the restraint order was listed as "must be calm, cooperative, able to discuss episode leading to restraints, must be free from signs and symptoms of aggression and agitation x 60 mins." The justification for restraint was listed as "patient requires time to regain control of self-behavior." The restraint flowsheet documenting 15 minute checks stated that the recipient was agitated and complaining to staff, pulling on restraints, arguing with staff, cursing, talking to himself, restless, upset, angry, denies any wrong doing, threatening, refusing to take responsibility and stating "my lawyer is going to have fun." A restraint review form completed by an RN (registered nurse) and two STAs at 12:00 p.m. stated that the recipient was "stating that he is not crazy and doesn't belong here and shouldn't be here, difficult to redirect, easily agitated." At 1:00 p.m. another RN and two STAs completed a restraint review form stating that the recipient was "angry, responding to internal stimuli." At 2:00 p.m. another restraint review form completed by another RN, a Doctor and an STA stated "patient continues to threaten staff, cursing, exhibiting increased agitation, Dr [name] reviews release criteria with patient, patient states he understands and apologized for his actions. Patient not meeting release criteria as of now." The release criteria listed on the restraint order was listed as "must be calm, cooperative, able to discuss episode leading to restraints, must be free from signs and symptoms of aggression and agitation x 60." A second order for restraint showed that the recipient was restrained an additional 2 hours (from 3:00 p.m. until 5:00 p.m.) with 15 minute checks. The reason for restraint is listed as "continuation: patient remains hostile, cursing, belligerent, making racial slurs and threatening others." Interventions used before restraint are listed as "empathetic listening, distraction, verbal support, other, conflict resolution, reassurance, and medications IM [intramuscular]. Fails to calm patient." The release criteria is listed as "must be calm, cooperative, able to discuss episode leading to restraints, must be free from signs/symptoms of aggression, agitation x 60." The restraint flowsheet documented that during 15 minute checks the recipient was demanding to get up and see a nurse, mumbling, restless, wanting released. The restraint review form completed by a RN and two STAs completed at 4:00 p.m. stated "the patient is more cooperative, calmer, still not quite ready for release." Another review completed at 5:00 p.m. by the same RN and two STAs stated "patient cooperative, calm, admitted to why he was in restraints and what he needs to do in the future to stay out of restraints. Patient states he will follow module rules and go to his room to cool down if another patient gets on his nerves or he will ask for a PRN." The post episode debriefing form documented that the recipient was able

to identify stressors occurring prior to seclusion or restraint stating "another guy made me mad." The nurse documented the reason why previously identified early interventions were not employed as "patient escalated too quickly." A restriction of rights form was completed for this restraint episode and stated the reason that his emergency preferences were not utilized was because he was "highly agitated and violent." The recipient "went to attack a peer and continued to make direct threats to kill." There was no documentation that emergency medication was given during the restraint episode.

D. Progress Notes: A 10/29/13 nursing note documented that the recipient was received on the unit and educated about his medication and asked to sign the consent, but he stated that he wanted to talk to his family first. It was noted that the recipient "states he has HTN [hypertension] B/P 150/90, 78, 16. Pt [patient] provided with safe environment and will continue to monitor Pt on module." A 11/2/13 nursing note documented that the recipient became upset over the phone and requested something to calm him down. It was also documented that he "didn't sign the med. consent form so Dr. [name] was called for T.O. [telephone order] emergency enforced Lorazepam 2mg PO [orally] Pt. accepted and was given ROR [restriction of rights]." On 11/3/13 a case note from a medical doctor documented that the recipient was placed in restraints "after hitting a peer and not following basic rules." It also noted that he "was undressing and threatening staff. Pt is very agitated, pressured speech, paranoid ideation, and appears to be listening to voices off to his left side. Also talking some to himself when alone. Denied hearing voices. Consented to pills then refused. IM [intramuscular medication] given." Another nursing note dated 11/3/13 documented that the recipient "refused P.O [oral] Haloperidol [Haldol] 5 mg and Lorazepam 2 mg PO as ordered by Dr. [name]. Emergency enforced Haloperidol 5 mg and Lorazepam 2 mg IM given. ROR [restriction of rights] given at this time." The medical doctor entered a case note on 11/3/13 approximately 3 hours later which stated that the recipient was "agitated when approached. Name calling staff. Not cooperating or able to control his impulses. Will continue 4 pt. [point] restraint protocol. Appears that pt [patient] needs medication regiment started soon. Pt. verbally threatening staff but extremely cooperative with me. Pt. is manipulative." A 11/4/13 nursing note documented that new psychotropic mediation orders were received and sent to pharmacy and the MAR (medication administration record) was updated. A nursing note dated 11/4/13 documented that the recipient was "compliant with medication. Restriction of rights given for emergency enforced medication. No unusual response to Olanzapine." Another nursing note dated 11/5/13 documented that the recipient was "given restriction of rights and medication education provided. Emergency enforced medication given orally at this time." On 11/5/13 a psychiatrist's note stated that "court enforced emergency psychotropic meds due to his severe MI [mental illness] and refusal to take meds voluntarily. Recently he was placed in restraints for [illegible] against a peer without meds he may become an imminent threat to inflict harm to self or others. Cont. same order X 24 hours." Nursing notes on 11/5/13 and 11/6/13 stated again that the recipient was "compliant with medication. Restriction of rights given for emergency enforced medication." On 11/6/13 a nurse's note documented that the recipient was "scheduled for court on court enforced medication, medication advisement sheets reviewed and a copy was given to pt on Olanzapine, Lorazepam, Risperidone and Clonazepam." The medical director also entered a case note on 11/6/13 stating she "discussed the patient with the treating psychiatrist and staff. Pt. threatened staff and attacked peer and required to be in restraints. Emergency medication started yesterday and petition to be filed today per discussion. Discussed with

treating psychiatrist that pt. stays a serious threat of harm without use of psychotropic medication. Pt. is to be continued on emergency enforced meds as per the Mental Health Code." A medical doctor's note on 11/7/13 also documented that emergency enforced psychotropic medications should be continued due to the recipient being an imminent threat to harm self or others without them. On 11/7/13 a psychiatric note was entered by another medical doctor who documented that the recipient was seen for assessment for continued emergency medication and stated that the recipient "has a history of aggression when not on psychotropic medications and would become an imminent threat of harm if he did not continue to receive psychotropic medication." On 11/8/13 a nurse's note documented that the emergency enforced medications were "crushed and observed". On 11/9/13 a medical doctor again assessed the need for continued emergency enforced medication (petition to court on 11/7/13) and agreed that without the medication he was aggressive and threatening and renewed his emergency enforced medication for 24 hours. On 3/3/14 a psychiatrist note documented that he met with the recipient to discuss consent for voluntary medications. The recipient "agreed to consent for voluntary meds. He did sign informed consent." The psychiatrist made a note to discontinue court authorized involuntary administration of medications and to continue the same medications (Olanzapine and Lorazepam) without being "enforced."

D. Order for Involuntary Treatment: On February 26, 2014 the Court granted a Petition for Administration of Court Authorized Involuntary Treatment and Ordered involuntary treatment due to "deterioration of his ability to function and threatening behavior."

III...Facility Policies:

A. 02.04.00.06 Medication Compliance states that "*Patients have the right to refuse medication under the Mental Health Code unless they are imminently physically dangerous to self or others. The nurse who administers medication should always encourage medication compliance and should explore with patients any reasons for their reluctance to take medication. Medication non-compliance must be addressed in the patient's treatment plan and a consistent intervention formulated by the treatment team members with involvement of the patient.*" The policy continues by stating "*Patients for whom medication non-compliance is or has been an issue will have that problem identified and addressed in the Master Treatment Plan. The plan will include the patient's perspective and reasons for non-compliance. Treatment plan interventions for patients who are prone to non-compliance shall include individual patient teaching sessions by the assigned RN. The RN will encourage the patient to ask questions regarding medication and to discuss their concerns with the assigned psychiatrist. Patients requiring increased attention due to suspected current non-compliance will have specific interventions identified in their treatment plan. Mouth checks should only be utilized when determined by the treatment team.*"

B….02.04.00.02 Use of Psychotropic Medications states that "*Chester Mental Health Center prescribes psychotropic medication in accordance with Department of Human Services PPD 02.06.01.02*" Under section C of this policy it is stated 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.*" Section D of this policy states "*Regarding Refusal of Medication…The unit nursing supervisor will monitor the expiration date of any court order for medication. The unit nurse will provide the patient with Medication Information sheets. Seven days prior to the expiration of the court order, the psychiatrist will ask the patient to sign a Medication Consent form for voluntary administration of medication.*"

C…DHS 02.06.02.020 Administration of Psychotropic Medication states that "*it is the policy of the Department of Human Services (DHS) that medical staff shall prescribe and administer psychotropic medication to individuals served in State Operated Developmental Centers or Mental Health facilities in accordance with Section 5.1 of the Mental Health and Developmental Disabilities Administrative Act, the Mental Health and Developmental Disabilities Code, Sections 112.30, 112.80, 112.90 of the Treatment and Habilitation Services Rule and this Directive. Except as described herein, individuals shall have the right to refuse medication.*" Under Section III. Refusal of Treatment, this policy also states that "*An individual's refusal to take psychotropic medication does not in itself constitute an emergency. An individual's refusal to take psychotropic medication, as documented in the clinical records shall be honored except in the following circumstances…In an emergency, when treatment is necessary to prevent an individual from causing serious and imminent physical harm to self or others…there must be documentation in the individual's clinical record that staff explored alternative treatment options to contain the emergency. The documentation shall include a written explanation of the reasons why less intrusive means of treatment are not appropriate…the prescribing physician shall examine the individual and document his or her determination of the initial emergency and response in the individual's clinical record as soon as possible, but within twenty-four (24)*

hours…Psychotropic medication may not be continued unless the need for such medication is predetermined at least every twenty-four (24) *hours and the circumstances demonstrating that need are set forth in writing in the individual's clinical record. A redetermination is based on a personal examination of the individual by a physician or by a nurse with the consultation of a physician…treatment shall not be administered for a period in excess of seventy-two (72) hours excluding Saturdays, Sundays and holidays, unless the treating physician with the support of the interdisciplinary team files a petition for the Administration of Authorized Involuntary Treatment for a court order and the treatment continues to be necessary in order to prevent the individual from causing serious and imminent physical harm to himself or herself or others. If no such petition is filed, treatment must be discontinued…A notice regarding restricted rights of individuals shall be completed for each administration of treatment…"* Section B of this policy, Administration of Treatment on Court Order, states that the treating physician along with the interdisciplinary team may file a Petition for Administration of Authorized Involuntary Treatment with the Court to obtain court ordered treatment. The physician "*determines that psychotropic medication is clinically indicated for an individual who does at the time pose an imminent risk of serious physical harm to him or herself or others and the individual refuses such medication…"*

D. 03.03.00.02Unit Dose Preparation and Distribution System policy states that *"The RN/LPN who is responsible for administering the medications on that module will check each patients' current medication orders with the information on the preprinted inlay and the medication and dosage sent from pharmacy using the MAR as the current equivalent of the physician's order...Then after verifying the recipient, opens the unit dose package and administers the medication. After administering the medication, the nurse then charts the administration on the MAR prior to proceeding to the next recipient…"*

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) states "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. (b) Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the needs for emergency treatment are set forth in writing in the recipient's record. (c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's

record. (d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section.

The Code (405 ILCS 5/2-107.1) states "Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meets the criteria specified in the following paragraphs (A) through (G). (A) That the recipient has a serious mental illness or developmental disability. (B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought, (ii) suffering, or (iii) threatening behavior. (C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) of this subdivision (4) or the repeated episodic occurrence of these symptoms. (D) That the benefits of the treatment outweigh the harm. (E) That the recipient lacks the capacity to make a reasoned decision about the treatment. (F) That other less restrictive services have been explored and found inappropriate. (G) If the petition seeks authorization for testing and other procedures, that such testing and procedures are essential for the safe and effective administration of the treatment."

The Code of Federal Regulations (42 CFR 482.13) provides that: "(1) The patient has the right to participate in the development and implementation of his or her plan of care. (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. (3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates)…(c) Standard: Privacy and safety. (1) The patient has the right to personal privacy. (2) The patient has the right to receive care in a safe setting. (3) The patient has the right to be free from all forms of abuse or harassment. (d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records."

Conclusion

Although there was a Petition for Administration of Authorized Involuntary Treatment in the file dated 11/5/13, the first signed Order from the Court that was in the chart for Involuntary Treatment [medication] was filed on 2/26/14. However, on 11/4/13 a restriction of rights form documented that the recipient was given "emergency enforced medication due to psychosis. History of non-compliance and aggression." On 11/5/13 a restriction of rights was given for "emergency enforced medication due to psychosis. History of non-compliance and aggression." On 11/13/13 a restriction of rights form was completed documenting that **court enforced**

medication was administered "due to psychosis. History of non-compliance and aggression for 90 days." Each time medication was given, it was noted on the restriction of rights forms that "individual preference was not utilized because "medication is only choice for long-term help with psychosis." The Code (405 ILCS 5/2-107) guarantees the right to refuse medication unless it is 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 reason listed on the restriction of rights forms for administering emergency enforced medication is listed as "due to psychosis. History of non-compliance and aggression" and does not meet the Codes requirements for preventing "serious and imminent physical harm to the recipient or others" when no less restrictive alternative is available. Also, the TPRs dated 11/19/13, 12/17/13 and 1/13/14 all stated that the recipient was on court enforced medication, however the HRA found no Court Order for medication until 2/26/14. Therefore, since the Code's requirements for emergency medication were not met and there was no documentation in the chart indicating that the recipient was under a Court Order for medication at the time it was administered, this allegation is **substantiated**. The HRA makes the following **recommendations.**

1. Ensure that emergency medications are administered in accordance with Mental Health Code provisions and documented accordingly. The HRA acknowledges that this issue has been addressed by the facility in response to previous HRA reports and training was held to retrain staff on these guidelines. Therefore, the HRA recommends that the individual staff members involved in this case specifically should be counseled to ensure that they understand facility policies and Mental Health Code guidelines for emergency enforced medication to ensure compliance in the future.

2. Ensure that medication is not given, absent recipient consent or an emergency, when there is not a court order. The Administration must review the process by which staff are notified when there is a Court Order for medication and how that is documented in the chart and determine if improvements can be made to prevent miscommunication as to whether or not there is a Court Order in the future.

3. Upon review of the chart, it was determined that documentation in the TPRs was inconsistent. For example, the Psychiatrist stated that the recipient was reluctant to accept medications; however the nurse stated that he was compliant. Also, even though the nurse stated the recipient was compliant with medications, he was placed on a "crush and observe" order for medications. The HRA recommends that the treatment team address and clarify these discrepancies in the treatment meetings and on the TPR reports in the future.

4. Stop repeatedly basing decisions on not using a recipient's emergency intervention preference because "medication is the only choice for long-term help with psychosis." It contradicts the whole point and the Code's very intention that people with long-term psychosis in *emergent* trouble have the right for their preferences to be considered; it has absolutely nothing to do with long-term psychosis but *imminent emergencies* (405 ILCS 5/2-107 and 2-200). Chester staff should provide detailed documentation in case notes and on restriction of rights forms providing detailed information as to why emergency medication is required versus using the recipient's emergency preferences.

5. Stop qualifying “no signed consent” or “no consent obtained” as emergencies when any recipient requests PRNs. Consent is based on information and capacity, not signatures, and all recipients have the right to withhold or provide consent at any time absent a true need to prevent serious and imminent physical harm when no less restrictive alternative is available. Furthermore, record documentation that portrays a recipient as physically harmful enough for involuntary medication when they are not is not only inaccurate, but inflammatory and damaging as this information becomes each recipient’s history and stays with him indefinitely (405 ILCS 5/2-102a-5 and 2-107). Document when a recipient refuses to sign a consent form.

Suggestion:

Ensure that physicians provide recipients with explanations regarding why a recipient-requested medication cannot be prescribed.