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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9002
Andrew McFarland Mental Health Center

Case Summary: Violations were substantiated. The facility made policy corrections and educated staff. Both records follow.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of possible rights violations in the care provided to an inpatient at Andrew McFarland Mental Health Center in Springfield. Allegations are that all outgoing calls were restricted without harm, harassment or intimidation, forced medications were given without the need to prevent serious and imminent physical harm, restriction notices were incomplete and the patient was not asked if anyone was to be contacted, which, if substantiated, would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

McFarland is a Department of Human Services hospital with 51 beds devoted to male and female forensic patients with minimum to medium securities.

The matter was discussed with staff involved in this patient's care. Relevant policies were reviewed as were sections of her record with authorization.

COMPLAINT SUMMARY

The complaint states that the patient's right to use the telephone was restricted after she called 911 for being served spoiled milk and bad meat. A nurse reportedly told her she was prohibited from making outgoing calls for a week although the restriction notice said for two days. There was a second incident about two weeks later following an attempt to reach 911 for similar reasons when all outgoing calls were restricted for another week, but this time along with an emergency injection. Her restriction forms were said to be incomplete and she was never asked if she wanted anyone notified.

FINDINGS

Records

The record includes two restriction notices for June 2014. The first one came on the 7th, two days after admission, and states that the patient was allowed no outgoing calls for dialing 911 and yelling into someone else's phone call to dial 911. A two-day restriction is noted and the staff person marked that she provided a copy to the patient and notified her mother as designated. The staff failed however to sign the form. The corresponding progress note describes a situation in which the patient accused another of punching her in the nose while she was sleeping and that she was refused pain medication. She called her mother to complain and after some back and forth was placed on the restriction for asking incoming callers to dial 911, the number of days for which is not mentioned. She was counseled against calling for ambulances or police help, and was noted to be less strident an hour later after taking anti-anxiety and pain medication. A physician's order accompanies the restriction: "phone restriction - calling 911".

The second one was completed on the 20th. It states that the patient was given emergency forced medication for being in imminent danger of harming herself or others. She was also restricted from using the phone for seven days for calling 911 because she thought someone tampered with her food tray. The form in this instance was signed by a nurse, and it notes that the patient's emergency intervention preference was used per the treatment plan and that she was given a copy but wanted no one else informed. According to the nurse's related progress note, the patient dialed 911 to report that her tray had been tampered with and that she yelled and threw a glass of water on the front desk after they stopped her call. An emergency injection was ordered and a restriction notice was done for that and the phone for seven days. The accompanying physician's order states that the medication was needed for extreme agitation; the telephone was restricted: "…x7 days for dialing 911 - patient cannot call out". There are no documented references to having explored or attempted alternatives.

The treatment plan in place at the time of these incidents shows that the patient declined to designate an emergency intervention preference. Nothing in the admission records or the treatment plan listed persons designated, if any, to receive notice of restrictions, at least in the records provided.

Interviews

The nurse who completed the first restriction is no longer employed at the facility and was not interviewed. Regarding telephone restrictions in general, program leaders agreed that restricting all outgoing calls and leaving forms unsigned are not common practice. Typically the staff would dial requested numbers during a restriction period, avoiding the person being harassed; not every outgoing call is prohibited. It was unclear if this particular restriction lasted two or seven days. A manager suggested that seven day restrictions seem to be standard procedure and applied throughout the facility. On the question of whether calling 911 in itself is considered reason to restrict, the staff said that those calls always land restrictions and that even calling one time without an emergency is not allowed; it is considered an abuse of the emergency system.

Regarding the second restriction incident, the nurse said the patient again tried reaching 911 after complaining that someone tampered with her food, which was clearly not an emergency. This time the patient became increasingly angry, her behavior escalating when they ended her call. There were attempts to redirect and calm her but none of it worked. She threw a styrofoam cup at the nurses' station, not glass, and the imminent danger was to the entire milieu. She was so disruptive that she could have harmed anyone in the area or caused adverse reactions from other patients. The emergency medication was a last resort. They admitted that documentation to reflect that could have been better. Asked about the patient's emergency preference discrepancy on the form versus her treatment plan, the nurse said she should have checked on that although it was agreed that sometimes it is difficult to do during emergencies. On providing notifications, the staff said that patients are always asked at admission and also at the time of any restriction if they want someone notified, but they were unsure of where that is documented in respective records.

It was mentioned incidentally that complaints about one's food are looked into by the facility's Office of the Inspector General liaison, in this case without a finding.

CONCLUSION

McFarland Procedural Guide on Individual Rights and Restriction of Rights (Series #: HR126), states that individuals are allowed to conduct private telephone conversations. Any restriction is to be properly documented using the Notice Regarding Restricted Rights of Individuals. Unimpeded, private and uncensored communication by telephone may be reasonably restricted only in order to protect from harm, harassment or intimidation. A physician's order is required and a restriction notice is given to the individual and anyone designated, which identifies the date, time, nature, rationale and duration of the restriction, all in compliance with Mental Health Code requirements (405 ILCS 5/2-103, 2-200 and 2-201).

Department Administration of Psychotropic Medication policy (02.06.02.020) states that an individual's refusal to take medication shall be honored except during emergencies when it is necessary to prevent serious and imminent physical harm. A physician, or nurse in consultation with a physician, determines that an emergency exists based on personal examination. An order will follow. Documentation in the record must include that staff explored alternative treatment options to contain the emergency and shall include a written explanation of the reasons why less intrusive means are inappropriate. The policy is in line with Mental Health Code requirements under Section 5/2-107:

> *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 Code provides that any recipient 12 years and older must be informed of the right to designate any person or agency of his or her choosing should any right be restricted (405 ILCS 5/2-200 b). Whenever any right under Chapter II is restricted, the responsible professional shall give prompt notice of the reasons to the recipient and any person or agency so designated (405 ILCS 5/2-201).

The first part of this complaint alleges that all outgoing calls were restricted without the need to prevent harm, harassment or intimidation. In this patient's first incident just days after admission she was restricted from the telephone for calling 911 and then yelling into other callers' conversations for them to call 911. Her restriction was on all outgoing calls, the duration of which is uncertain but the notice cited two days. The second was also for trying to reach 911 and it prohibited all outgoing calls for seven days. Banning outgoing calls in both instances exceeded the Code's limits to only that communication which is potentially harmful, harassing or intimidating. This part is a substantiated rights violation. It can be said that in the first instance the patient harassed someone, whether other patients or whomever they were calling, and certainly additional attempts after being told to stop as in the second would seem like grounds for restriction; a finding cannot be substantiated there. But the stated practice of always restricting phone use for calling 911 one time fails to meet the Code's standard. An initial, one-time phone call, however inappropriate in the staffs' view, in no way constitutes the need to prevent harm, harassment or intimidation, nor does it abuse the emergency system if the patient is convinced he has a legitimate emergency when total protection from danger, harm, abuse, etc. in any hospital is never a guarantee. A rights violation of all subjected patients is substantiated.

The second allegation is that forced medications were given without the need to prevent serious and imminent physical harm. Based on the involved nurse's statements of the incident and what was potentially brewing coupled with her documentation on the need to prevent imminent danger, the use of emergency forced medications was not a violation of the patient's right to refuse medication. The problem is that although the nurse said she made several attempts to redirect before the injection, her documentation provides nothing in support, which falls short of program policy and ultimately the Code's intention for available least restrictive alternatives. The complaint is substantiated.

The third claim is that restriction notices were incomplete and the patient was never asked if anyone was to be contacted about her restrictions. The first notice was in fact left unsigned by the responsible staff person and does not meet proper documentation requirements under policy. That part of the complaint is substantiated. Staff assured that all patients are asked at admission and when rights are actually restricted if anyone is to be notified; their documentation in both of these instances indicate the same. That part of the complaint is not substantiated.

RECOMMENDATIONS

1. Stop the practice of banning all outgoing calls when one destination is being harmed, harassed or intimidated. All authorized staff including nurses and physicians must be trained in acceptable restriction practice. (405 ILCS 5/2-103).
2. Stop the practice of restricting telephone use whenever a single 911 call is made or attempted. The HRA offers help in any need for communication with emergency call centers. (405 ILCS 5/2-103).
3. Reassert policy with all nursing staff to document explored alternative treatment options to contain emergencies and to include written explanations of the reasons why less intrusive means were not appropriate. (405 ILCS 5/2-107 and Policy 02.06.02.020).
4. Complete restriction forms thoroughly (Policy HR#126).

SUGGESTIONS

1. Remind staff to use language that reflects precise behaviors instead of sufficing with unexplanatory and arguable phrases like "to prevent imminent danger to self and others".
2. Physicians and nurses should familiarize with each patient's emergency intervention preference and consider them whenever the need arises. Treatment plans should be updated as preferences change (405 ILCS 5/2-200d).
3. The staff thought that seven-day phone restrictions were commonly applied on all units and seemed to be standard practice, although they were unsure of the reasoning. The facility should take a look at this, along with the "no outgoing calls" practice, as any blanket seven-day rule is not an individual determination and may not be a reasonable restriction for everyone (405 ILCS 5/2-102a and 5/2-103).
4. Review the need to clearly document in patient records all designations for restriction notification.
5. Provide written drug information on all psychotropics used for emergency purposes if they are unscheduled and/or not consented (405 ILCS 5/2-102 a-5).

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

Illinois Department of Human Services

Pat Quinn, *Governor* Michelle R.B. Saddler, *Secretary*

Andrew McFarland Mental Health Center
Greg Donathan, Hospital Administrator

Donna Lynn, HRA Chair (IGAC)
401 So. Spring St.
521 Stratton Building
Springfield, IL 62706

RE: Case #15-050-9002

Dear Ms. Lynn,

This letter is in response to your recommendations for case # 15-050-9002 which include:

1. Stop the practice of banning all outgoing calls when one destination is being harmed, harassed or intimidated. Train authorized staff to acceptable restriction practices.
2. Stop the practice or restricting telephone use when a single 911 call is made or attempted.
3. Reassert policy with nursing staff to document explored alternative treatment options before restricting phone usage and to document reasons why less intrusive means were not appropriate.
4. Complete restrictions forms properly.

On October 8, 2014 Natalie Katauski, Quality Manager, attended the Clinical Nurse Manager's meeting to review issues and concerns with identified restrictions, specifically the requirement to fully and accurately describe the behaviors necessitating the for the restriction (4). The Clinical Nurse Managers were reminded to review each restriction to ensure they were completed correctly before they are sent to the Treatment Services Director/Quality Manager for auditing and filing purposes.

On October 10, 2014, all nursing staff were reminded that restrictions are not automatically set for a duration of 7 days, and that the treatment team will determine appropriate duration on a case by case basis. They were also reminded of our policy on Patient Rights and Restrictions of Such Rights (see attached Procedural Guide HR126) that indicates staff may dial the number for a person who is restricted from making calls on their own. It is not our policy nor is it acceptable to state "no outgoing calls" on the restriction form (Recommendations 1 & 2). We have also requested staff document as much information as possible concerning the need for the restriction directly on the restriction form

rather than making additional statements in a progress note (Recommendation 3). The attached procedure guide was modified and distributed to all staff October 31, 2014 to include language concerning duration of restrictions.

Suggestions for improvement included: remind staff to use "behavioral" statements when defining the reason for restriction, familiarize staff with emergency intervention preferences and ensure treatment plans are updated, ensure automatic seven day restrictions are not commonly applied to all patients, ensure records indicate designations for restriction notification, provide written drug information on all psychotropic medication used for emergency purposes if unscheduled/non consented.
Suggestions 1-4 were also covered in actions taken to address recommendations discussed previously. The last suggestion for improvement has been forwarded to the Medical Executive Committee for consideration.

Thank you for the opportunity to address systems issues that allow our hospital to improve performance and patient safety.

Sincerely,

Greg Donathan, LCSW

Greg Donathan, LCSW