FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 16-050-9008
16-050-9009

MEMORIAL MEDICAL CENTER

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation into the care provided to patients within Memorial Medical Center's behavioral health program in Springfield. The allegation in #9008 is that the facility does not post patient rights conspicuously in public areas. Allegations in #9009 state that there are no clear decisional capacity statements documented in patient records, psychotropic medications are administered to patients who lack decisional capacity and/or who object to the administration when there are no emergencies or judicial orders, and, upon the filing of petitions, psychotropic medications are given routinely in nonemergency situations.

Substantiated findings would violate patient protections under the Mental Health Code (405 ILCS 5).

Part of the Memorial Health System, the Medical Center's inpatient behavioral health program currently holds thirty-six beds, twenty-one of them on an acute section of the unit. Psychiatrists and residents come from the neighboring Southern Illinois University School of Medicine. The issues were discussed with representatives from the program and legal department. A draft policy was reviewed, as were seven masked records of patients petitioned for involuntary treatment between January 1 and April 30, 2016.

FINDINGS

#9008: The facility does not post patient rights conspicuously in public areas.

The HRA alerted management on two separate occasions that there were no rights posted on the unit. We were told they were up previously and that patients tear them down. Photos showing postings in various areas of the unit were forwarded later, and we observed them securely displayed in full view during our latest visit.

CONCLUSION

Pursuant to the Code, "Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility." (405 ILCS 5/2-200).

A violation is substantiated, and has been resolved.

#9009: There are no clear decisional capacity statements documented in patient records, psychotropic medications are administered to patients who lack decisional capacity and/or who object to the administration when there are no emergencies or judicial orders, and, upon the filing of petitions, psychotropic medications are given routinely in nonemergency situations.

Interviews

The staff said that they currently have no medications policy in place but one is being drafted; they just follow the Mental Health Code. Asked about training on the Code's informed consent and various routes of treatment requirements, they said that for nursing, Code issues, patient rights, de-escalation techniques and other topics are covered during orientation and that the nurse managers review the Code verbally and provide handouts from there. The program's chair, a contracted university physician, said that physicians discuss anything necessary in monthly staff meetings and try to keep residents updated.

It was unclear whether they have a formal informed consent process for psychotropic medications. They explained that physicians and residents handle the education and sharing of written materials and that different physicians use different printouts, evidence of which, along with patient decisional capacities, should be indicated in the history and physical. They were asked to provide that evidence from the records in this sample and we have received nothing to date. It was offered that the capacity requirement could be added to the policy draft, and they provided a copy of that and their new informed consent form, patterned after the state-issued one that has a capacity determination check box. A close outline of the Code's treatment course from voluntary through court-petition, the HRA notes that the written education component is absent from the draft as well.

On procedures for using emergency medications, nursing managers said that a patient's emergency treatment preference is noted on the treatment plan, although we pointed out that nothing was mentioned on the two plans found in these records. Persons or agencies designated for restriction notification goes on a separate form completed during admission, and a notice is to be completed and forwarded with every emergency administration. They use emergency medications when necessary to prevent serious and imminent harm. Time is spent with the patient observing certain behaviors and gestures that they come to know as triggers. Memorial suggested that the word imminent is not defined and that imminence is something that will develop. In other words, it takes a couple days to watch and understand a patient's emergent behavior and triggers. They also spoke of "capacity fluidity", how a patient may have decisional capacity for one type of treatment but not another. This makes it possible to give voluntary psychotropics while at the same time filing a petition for ECT, presuming that the patient can provide consent for the medication but not the ECT, which should be exemplified in the records.

Records

Patient A (admit: 12/30/15 discharge: 1/28/16). There is no capacity statement and no evidence of informed consent anywhere in the record before scheduled, voluntary Haldol was prescribed on 12/31 and administered on 1/2 and 1/3 and Depakote on 1/4. A petition to administer medications was filed on 1/11, stating that the patient lacked decisional capacity. The record presented a patient who was extremely difficult and physically aggressive during his stay, being restrained and/or secluded six times and receiving multiple forced injections, most of which were combinations of Haldol and Ativan. According to physician and nursing notes, MARs and restriction notices, he got his first injection, one time on 12/30 for hitting at staff and posturing in a threatening manner; twice on 12/31 for the same; once on 1/1 for making threats to harm the staff while posturing toward them and once on 1/2 for the same. He was free of incident on 1/3 but on 1/4 was injected for throwing his coffee and not calming down. More followed. He got one on 1/6 for lurching toward the doctor as if to physically harm him. He was prevented from doing so and agreed to go to his room where he continued to be threatening; one time on 1/7 for similar actions, and he was offered oral medications and refused; once on 1/8 for charging at a nurse and once on 1/9 for screaming at staff that he was going to kill them. He was given two on 1/14, in the morning for yelling at the doctor and staff to leave his room and then going at them with a pen; the staff ran out and shut the door for safety, and later for throwing his food tray and attempting to scratch at staff who approached him. He received a forced injection once on 1/16 after threatening to throw a phone book at a nurse; he agreed to go to his room but failed to calm down. He received two on 1/17, one for refusing to stop yelling on the phone and threatening staff, although how is not mentioned, and another three hours later for "continual threatening of staff", again not defined. The corresponding restriction notice referenced the earlier event and that it was twenty-four-hour emergency medication, which followed an order to give for twenty-four hours if the patient was verbally or physically aggressive. There were three injection instances on the 18th, the first in the morning after he ran toward the physician with fisted hands and spitting on a nurse and after continuing to raise his fists and threaten to kill the staff once he was contained by security; he was placed in seclusion as well. The second occurred four hours later, still secluded after he was heard thrashing about his room, slamming the toilet seat and bathroom door repeatedly and the third for doing nothing according to nursing notes, willing to take his shot; "agitated though". An order was written that day to give three injections over the next twenty-four hours if the patient refused oral doses. On the early morning of the 1/19 he was at the nurses' desk and became agitated as he talked about his family. Per the nurse's note, he threw his cup of Pepsi against the wall and he cursed and yelled as he went back to his room. Security was called and the patient was given an injection, which he allowed without difficulty. An order was written to continue the emergency order for another twenty-four hours. He took his oral doses of Haldol and Depakote as scheduled for the rest of that day. He had one oral dose each of Haldol and Depakote on 1/20 and 1/21 and was given nothing on 1/22 and 1/23. Early a.m. on 1/24 he got in a nurse's face, pointed his finger at him and said he would kill him. Redirections failed and injections were given at that time. An order was written for injections if the patient refused by mouth over the next twenty-four hours. He was awakened at 10:30 a.m. and offered medications, which he refused, and was then given an injection. He was given a third later that afternoon after being offered oral medications and lunging at staff when the needle was presented. He received a fourth injection later that evening after refusing his oral

medication and scratching a nurse. On 1/25 he took three oral doses of Haldol and at one point in the evening he told a male staff member he would harm him and then chest-pumped him; he was subsequently given an injection and emergency orders were continued another twenty-four hours according to nursing and physician notes. At 5 the next morning the patient had been sleeping and was noted to have no agitation, no issues, and no harm to self or others. At 8 a.m. he was offered oral medication; he threw them at the nurse and then slammed his room door in her face. She returned with an injection and he became physically aggressive, attempted to hit her; he got the shot and ended up in restraints for two hours and he took two oral doses later that day. On 1/27 in the early a.m. he threw his glasses at staff and charged at security; he was given an injection and restrained again for three hours. He got physically aggressive with staff again a short time later and had to be carried to his room where he was injected and restrained for a few more hours but remained under seclusion and observation for the day. Finally, in the late afternoon, he was given an injection "due to having agitation and no insight into why he is in seclusion" according to the nurse's note.

Missing from Patient A's record are restriction notices for injections on 12/31, 1/2 (also for seclusion), 1/4, 1/9, 1/14 (18:00), 1/17 (14:30), 1/18 (21:48), 1/19, 1/24 (10:30 and 22:00) and for all oral medications he was not allowed to refuse following twenty-four-hour emergency orders through discharge. Almost all notices indicated that the patient's guardian was notified and that he had no emergency intervention preference.

Patient B (1/5/16 - 1/25/16). The patient was administered non-emergent Abilify eleven times between 1/6 and 1/23, Ativan seventeen times between 1/7 and 1/23 and Zoloft thirteen times between 1/12 and 1/23. There is no capacity statement and no evidence of informed consent anywhere in the record for these medications, meanwhile a petition to administer ECT was filed on 1/6 indicating that she lacked the capacity to make a reasoned decision about the treatment. There appeared to be no forced medications or filed medication petitions during her stay.

Patient C (1/22/16 – 2/5/16). There is no capacity statement and no evidence of informed consent anywhere in the record before Patient C was given non-emergent Haldol on 1/23 and a voluntary as needed dose on 1/30. Forced injections were given once on 1/25 after he became angry, pounded his fists into his hands and chest and de-escalation attempts failed to calm him. The accompanying restriction notice referenced the need and that he had no intervention preference or designated anyone to be notified. Three times on 1/31, first at 11:50 a.m. when he became angry at staff, clenched his fist and tried to hit a nurse. Staff and security tried to subdue him and two were injured in the process according to the notes. He was restrained and given injections and a restriction notice was thoroughly completed. An order was written to give three forced medications that day by mouth or injection. Two more injections followed: one in the afternoon for "screaming/proclaiming, none of my behavior was wrong", per the nursing notes, and the next later that evening when he was quoted as saying he was not going to threaten or hurt anyone; a nurse explained the he could choose to take the dose by mouth or have a shot; he took the shot. Restriction notices were not completed. Twenty-four-hour emergency orders were continued on 2/1, and he was given four. The first at 8:00 a.m. when he was described as disorganized and agitated, screaming at the staff; he went to his room where he became very agitated in speech and body language, jumping up and down. He was given an injection and told to stay in his room. A second came at 12:28 p.m., for being agitated and threatening toward

staff, although how is not mentioned, and for punching his fists together; he was secluded and given an injection and was then place on a room restriction. A third came at 4:15 p.m. for refusing an oral dose and a fourth for no apparent reason as he was described in nursing notes as being cooperative. Only the noon injection was accompanied by a restriction notice, which was filled out entirely. Emergency orders were continued on 2/2. Four injections were given, one at 8:00 a.m. and the other at 9:44 a.m. but there are no nursing entries to explain them, except the physician wrote that during morning rounds the patient kept saying bitch and was threatening to the him and the staff, although how was not mentioned. Two more followed at 4:27 p.m. and at 8:55 p.m. for no apparent reason and the only documented descriptions for that time was that he was "somewhat irritable" when having to take them. Only one restriction notice was completed at the 9:44 injection, which referenced an event from the day before; it was completed thoroughly. Emergency orders were continued on 2/3 and a petition to authorize medications was filed as well. Around 9 a.m. the patient came out of his room and complained about his physician, saying he was not listened to and that this was the kind of thing that makes him go off. He hit his hands together and was told to go back to his room, which he did and he was given an injection without trouble. He complied with three additional oral doses that day, not being allowed to refuse. Only one restriction notice was complete, which was for the injection. On 2/4 he complied with an oral dose in the morning. A restriction notice was not completed. A restraining order against the medications was issued that morning; the emergency order was discontinued and there were no more administrations through discharge.

Patient D (2/7/16 – 3/2/16). Ativan and Zyprexa were ordered on admission and there is no patient decisional capacity statement or evidence of informed consent in the record at that time. Neither seemed to be given voluntarily or for non-emergencies, however. There were two forced injection episodes before a petition to authorize medications was granted on 2/19. On 2/8 the patient was restrained for getting physical with other patients and staff, inviting them to fight. He was given an injection at the onset at 1:10 p.m., and a complete restriction notice followed. At about 4 p.m. a wrist was released and the nurse described the patient as calm, but he began yelling profanities as the nurse left the room. He continued with a menacing tone of voice and would not respond to verbal de-escalation. "This just seemed to increase his agitation", wrote the nurse. "Pt sat up in his bed in a threatening way [restrained]… 'Go f*ck your boyfriend'. Pt was offered…Ativan at this time-declined and became increasingly angry, illogical. Writer believes the pt is a [sic] imminent danger due to hostile behavior, threatening demeanor…given Ativan [injection]." A rights restriction notice was completed.

Patient E (3/5/16 – 3/15/16). The patient was given non-emergent Abilify, Lorazepam, Depakote and Trazadone daily from 3/5 or 3/6 through discharge and Effexor daily from 3/8 through discharge. There is no capacity statement and no evidence of informed consent in the record for any of these medications. There appeared to be no forced medications or filed medication petitions during her stay.

Patient F (3/25/16 – 4/5/16). Zyprexa, by mouth or injection as needed was ordered the day after admission. While there appeared to be no initial administrations following the patient's refusals, there is no prior capacity statement or evidence of informed consent. On her second day, the patient's physician wrote that he discussed risks, benefits, side effects and alternatives with her and that she did not fully understand what was being said. Later that day she was given a forced

injection of the Zyprexa for hitting and slapping at staff after refusing her medication according to the corresponding restriction notice. The notice indicated that no one was to be notified, but not whether she had an emergency intervention preference, whether her preference, if any, was used and there was nothing related on her treatment plan. A petition for medications and ECT was court-filed on 3/28 stating that the patient lacked the capacity to consent to either, and a hearing was set four days ahead. On 3/29 the physician referenced the completed petition and that after discussing medicine specifics with the patient she agreed to take Risperdal and Lithium; orders were written to start, both of which were offered but refused for the next few days until they were discontinued. She was given more Zyprexa in the meantime: once by injection on 3/29 for throwing her food tray across the hall; she refused an oral dose but took an injection "willingly", and once daily by mouth without apparent incident until 4/1 when they were discontinued before her transfer.

Patient G (4/4/16 – 4/22/16). Xanax was ordered on admission and given twice, Citalopram three times, and Ativan, Zyprexa and Venlafaxine were started a day or two later and given daily through discharge, Lithium for two days, all by mouth, voluntarily and without evidence of prior informed consent. A capacity statement was not entered until 4/7 when the physician accepted a health care surrogate form in which the patient was determined to lack decisional capacity and have no advance directive, although the patient's surrogate was said to be checking on the directive. Physician notes on 4/8 stated that patient had no capacity, no advanced directive and that a petition for ECT was being filed. The filing was done on 4/11 but ECT was not administered in the interim. On 4/18 she was said to have improved and the petition was dropped, and on 4/20 just before discharge, there was a Power of Attorney form in the chart, the agent consented to all medications and the patient now had capacity and consented as well according to the physician. Several forced injections were given during her time at Memorial: 4/6 through 4/17. On 4/6 she awoke in an anxious state, resisted help in the bathroom and was startled by a nurse when getting off the toilet, nearly striking her, and she got an injection. Although the nurse wrote the patient was compliant, there was no indication that she had a choice or an opportunity to refuse and there was no accompanying restriction notice. The physician's note for the event stated that she got the injection because of agitation and psychosis after grabbing the nurse. There were two injections on 4/7, in one instance fighting with staff to get out of her chair and being caught before falling and the other for attempting to get out of her chair per the nursing notes. Again, no indication of being allowed an opportunity to refuse and no restriction notices. She got an injection on 4/9 after becoming agitated, going into other peoples' rooms and grabbing a staff member's wrist to drag her down the hall; she refused an offer for an oral dose and was given the shot according to nursing notes and the restriction notice. On 4/10 for grabbing staff and not being able to redirect—given injection and a restriction notice; 4/11 for hitting and kicking at staff and not being able to redirect—given an injection without a restriction notice; 4/15 for similar behavior, with a restriction notice and on 4/17 for the same but without a restriction notice. All notices indicated that the patient had no preference for emergency intervention and that her designated person was notified.

CONCLUSION

Under the Mental Health Code,

If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1…. (405 ILCS 5/2-102a).

(a) 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 need 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. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition. (405 ILCS 5/2-107).

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;

(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;

(3) the facility director;

(4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities,

and amending Acts therein named", approved September 20, 1985,[1] *if either is so designated; and*
(5) the recipient's substitute decision maker, if any.

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. (405 ILCS 5/2-201).

There are no clear capacity statements documented in patient records:

A patient's treatment course hinges on his capacity, and physicians are required under the Code to enter a written statement at the time treatment is proposed of whether the patient has the capacity to make a reasoned decision about the treatment, which goes in-hand with providing informed consent. Although there are several references to patients in this sample having lack of insight or judgment, not one contains a clear capacity statement when treatment was ordered until a petition was filed. **Seven violations are substantiated**. Further, with the exception of Patient D, non-emergent medications were started without documented evidence of having informed consent. **Six violations are substantiated**.

Psychotropic medications are administered to patients who lack decisional capacity and/or who object to the administration when there are no emergencies or judicial orders, and, upon the filing of petitions, psychotropic medications are given routinely in nonemergency situations:

The Code states that if a patient lacks capacity, treatment may only be given pursuant to an emergency or court order. It provides one standard to force medications in an emergency when treatment is refused, and without a court order, which is to prevent serious and imminent physical harm and no less restrictive alternative is available. Once petitions are filed, emergency administrations may only continue if the need to prevent serious and imminent physical harm still exists.

Patient A was indeed a very ill, difficult and dangerous patient according to the documentation, and, there were many appropriate reasons to force treat him and many reasons not to force treat him. He was force-medicated on the 17th for yelling on the phone, refusing to get off and threatening staff and then again later that day for continually threatening staff, but both were without any description of how he was threatening or if the threat met the need to prevent serious and imminent physical harm. The third injection on the 18th carried no documented hint whatsoever of an emergency. On the 19th he threw his Pepsi against a wall and then went to his room with no further difficulty and he got a shot; he left the scene with no further difficulty, which is a least restrictive alternative. This seems disciplinary. He was not allowed to refuse the rest of the day's medication without a single documented emergency or an opportunity to refuse or an available least restrictive alternative if there was an emergency, and, since a medication petition had been filed on 1/11, the oral medications administered were given to a man who lacked capacity. The same for when he took his oral doses on 1/20 and 1/21. On

the morning of the 1/24 he got too physically close to a nurse and was appropriately injected after redirections failed, but a few hours later he was awakened from a nap, offered an oral dose and was given an injection when he refused—awakened from a nap. He was fine until approached with a third injection that day, only lunging at the nurse when the needle was presented. There was no need to continue the emergency order, which only seemed to provoke the patient. A final injection was given "due to having agitation and no insight into why he is in seclusion", not even remotely necessary to prevent serious and imminent physical harm. Oral administrations followed on 1/25 when the patient had no choice, no emergencies and no less restrictive alternatives attempted if there were emergencies. **A violation of the patient's rights is substantiated on all allegations.**

Patient B was given voluntary, non-emergent medications forty-one times from 1/6 through discharge on 1/23 while a petition for ECT was filed on 1/6 stating that she did not have decisional capacity. **A violation is substantiated.**

Patient C was force-medicated twice on 1/31 following an emergency in the morning and a twenty-four-hour order. The two subsequent injections were after he screamed and proclaimed to have done nothing wrong and then for doing absolutely nothing, in fact, saying he intended to threaten and harm no one; not one additional instance of the need to prevent serious and imminent physical harm. He got four involuntary shots on 1/21, and while the first two that day are questionable, the subsequent two were based on nothing to suggest a need per 2-107 as he was described as being calm and cooperative when approached with having to take oral or injection. A twenty-four-hour emergency order continued on 2/2 when the patient was given four injections, two for saying bitch and threatening staff without explanation of how, and two more for doing absolutely nothing. A medication petition was filed on 2/3, stating that the patient lacked decisional capacity. Twenty-four-hour emergency orders continued that day, and the patient was given an injection for being frustrated, hitting his hands together and complying with the redirection to return to his room. He took three oral doses throughout the day, not able to refuse them and with no apparent emergency or attempts at least restrictive alternatives if there were emergencies. Without emergency, the oral medications were given to a patient who lacked decisional capacity. **A violation of the patient's rights is substantiated on all allegations.**

Patient D was restrained and given an emergency injection on 2/8 for what seemed were appropriate reasons. The second injection however, presents a problem. The man was restrained and noted to be calm, doing well. A nurse came in the room to check on him and when she turned to leave, he began yelling profanities. He would not stop and she would not leave. She correctly wrote that he just grew more agitated, and he ended up getting a shot. The nurse had the opportunity to carry on with the least restrictive alternative and leave the room. This was unnecessary. **A violation of the patient's rights is substantiated.**

Patient E was given voluntary, non-emergent medications throughout her hospitalization. According to the record, her decisional capacity remained undetermined, there were no petitions filed and there were no emergencies. **A violation is not substantiated**.

Patient F's medication and ECT petition was filed on 3/28 in which it was declared that she had no decisional capacity. Her physician noted the next morning that the petition had been filed and then proceeded to discuss specifics about Risperdal and Lithium, which the patient agreed to take. She ended up refusing them, but they were offered to the patient who had no decisional capacity nonetheless. **A violation is substantiated**.

Patient G was given voluntary, non-emergent psychotropic medications from admission through discharge; meanwhile the physician completed a surrogate form on 4/7 indicating that the patient lacked capacity and filed an ECT petition on 4/11 that indicated the same. This was before the petition was dropped on 4/18 and a POA document was introduced on 4/20 and the patient was found to have capacity, just before discharge. Medications were administered to a patient who lacked capacity. There were two emergency medication instances in question. On 4/6 the patient had just awakened, anxious and resisted help in the bathroom. She was startled by a nurse who tried to help her and she nearly struck her. She was startled and reacted; there was no emergency, no opportunity to refuse and no less restrictive alternative attempted if there was an emergency. Other injections were given on 4/7 as she simply tried to get out of her chair. The medication seemed to be intended to keep her contained since she was on fall precautions, but, regardless, she still has the right to refuse absent an emergency and the opportunity to refuse which were not honored. **A violation of the patient's right is substantiated**.

Notices must accompany all restrictions including the right to refuse medications at every instance. According to the records provided, notices were not completed for eleven emergency injections and all oral medications given when Patient A was not allowed to refuse; notices were not completed for eight emergency injections and all oral medications that Patient C was not allowed to refuse, and, notices were not given for three injections that Patient G was not allowed to refuse. A violation of their rights to have written notification in hand or to anyone they may have chosen to designate, is **substantiated**.

RECOMMENDATIONS

Require physicians to determine and document decisional capacity in each patient's record whenever psychotropic medications and/or ECT is proposed. (405 ILCS 5/2-102a).

Require physicians and nurses to secure informed consent before starting voluntary medications. (405 ILCS 5/2-102a).

Stop the practice of giving medications to patients who lack decisional capacity (405 ILCS 5/2-102a).

Stop the practice of force medicating for twenty-four hours when no emergency exists. (405 ILCS 5/2-107).

Train all physicians and nurses to follow the Code and give forced medication after petitions are filed *only* when the need continues to be necessary under 2-107a. (405 ILCS 5/2-107).

Train all appropriate staff to complete restriction notices whenever a patient is not allowed to refuse medication. (405 ILCS 5/2-201).

SUGGESTIONS

Add the written capacity statement and the written education component to the new medications policy. The draft also contains a section that calls for physicians to document once per day why refused services were not necessary and whether a patient meets petition criteria. This requirement applies to state-operated facilities only and it seems a potentially unreasonable task for Memorial's psychiatrists. Memorial's call.

The program should be sure that policies are established to cover all rights under the Code. "The Secretary of Human Services and the facility director of each service provider shall adopt in writing such policies and procedures as are necessary to implement this Chapter. Such policies and procedures may amplify or expand, but shall not restrict or limit, the rights guaranteed to recipients by this Chapter." (405 ILCS 5/2-202).

It is unclear whether Patient F had a choice in being medicated following her incident on 3/29. The record states that she refused by mouth but took the injection "willingly". The question is if she thought she was going to get one of them, like it or not. Nurses should be aware that not having the choice of no is always a restriction.

Be sure that emergency intervention preferences, designated or not, are documented on treatment plans. (405 ILCS 405 ILCS 5/2-102a and 2-200).

Of great concern is the apparent lack of any formal Mental Health Code training, whether with the Memorial staff alone or combined with physicians. Training is imperative and the program should consider combined training with SIU physicians to assure compliance and uniformity.

While physicians may cite capacity fluidity as they determine, they should be careful to honor statute and update records and documents accordingly.

Memorial said that it disagrees with the Commission's strict position on 2-107, instead saying that emergency medications may be administered as much as the physician directs within a twenty-four hour period and that the need to follow subsection (a) does not appear until the end of the Section in (d). The HRA points out that the documented need referred to in every subsection never changes from the established standard, which is the need to prevent serious and imminent physical harm and no less restrictive alternative is available and implores Memorial to rethink its position and seek formal training.

Designate a Mental Health Code-trained compliance officer to audit mental health records.

RESPONSE

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

Memorial HEALTH SYSTEM
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March 27, 2017

Via FedEx (807931600691)

James Bakunas, Chair
Human Rights Authority
Illinois Guardianship and
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401 S. Spring St.
521 Stratton
Springfield, IL 62706

RE: HRA #16-050-9008 and 9009

Mr. Bakunas,

On March 2, 2017, Memorial Medical Center ("MMC") received your report of findings in the aforementioned matter. In reply to this investigation, MMC wishes to submit the following response.

In regards to the recommendations applicable to the second complaint,

1. MMC is in the process of updating its Administration of Psychotropic Medication and Electroconvulsive Therapy ("ECT") policy to require physicians to determine and document decisional capacity in each patient's record whenever psychotropic medications and/or ECT is proposed.

2. MMC, through its Administration of Psychotropic Medication and Electroconvulsive Therapy ("ECT") policy, requires informed consent to be secured prior to the administration of psychotropic medications and/or ECT, except as otherwise allowed under the policy and the Illinois Mental Health and Developmental Disabilities Code (the "Code").

3. It is MMC's intention to provide medications in accordance with Illinois law and the proper practice of medicine.

4. It is MMC's intention to provide medications in accordance with Illinois law and the proper practice of medicine.

5. MMC is in the process of developing a computer-based learning (CBL) module outlining the requirements of the Code. The completion of this CBL shall be required annually of MMC staff. Physicians will be educated annually at a department meeting.

Memorial HEALTH SYSTEM
701 North First Street • Springfield, Illinois 62781-0001
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6. MMC is in the process of developing a computer-based learning (CBL) module outlining the requirements of the Code. The completion of this CBL shall be required annually of MMC staff. Physicians will be educated annually at a department meeting.

MMC hereby requests these responses be made a part of the public record.

Respectfully submitted on this day, March 27, 2017.

Sincerely,

Meghan L. Karhliker
Assistant General Counsel

SPRINGFIELD REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 16-050-9008
16-050-9009

MEMORIAL MEDICAL CENTER

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document, will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

X We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Meghan L Karkliker
NAME

Assistant General Counsel
TITLE

3/27/2017
DATE