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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 15-030-9015
JOHN J. MADDEN MENTAL HEALTH CENTER

Case Summary: The HRA did not substantiate the complaint that the recipient was administered forced emergency medication for no adequate reason and was grabbed by the neck and thrown to the floor during the Intake process.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at John J. Madden Mental Health Center (Madden). It was alleged that a recipient was administered forced emergency medication for no adequate reason, and that he was grabbed by the neck and thrown to the floor while in Intake. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Madden Mental Health Center is a 150-bed, Illinois Department of Human Services (DHS) facility located in Hines, Illinois.

To review these complaints, the HRA conducted a site visit and interviewed the Clinical Director, the Director of Nursing, the Hospital Administrator, the Quality Manager, and a Psychiatrist. Hospital policies were reviewed, and the recipient's clinical records were reviewed with written consent.

COMPLAINT SUMMARY

The complaint alleges that a recipient, on the day of his admission, was in Intake, wearing a hospital gown he had been given at a referring hospital. The recipient allegedly refused to take off his gown and declined to sign a voluntary application. Allegedly, three men (one a uniformed guard), threw him to the floor and grabbed him by his neck, injuring him.

Also, the complaint alleges that the recipient was administered forced psychotropic injections for no adequate reason, and he was not given a Restriction of Rights Notice.

FINDINGS

The clinical record (Face Sheet) shows that the recipient was admitted to Madden on 11/21/16 at 3:30 p.m. after arriving by ambulance from a local hospital's emergency room.

The recipient's Comprehensive Psychiatric Evaluation, completed on the Intake Unit on 11/21/16 at 2:46 p.m. states, "Chart reviewed. Patient examined. This is a 35 year old male with a history of non- compliance has been disorganized, labile, and delusional. Patient was on Risperidone 3 mgs qHS [nightly] and has not been taking it. Patient was agitated and was given i/m [intramuscular] medication for agitation in intake and was restrained in the emergency room. Patient was combative with the police on arrival in the emergency room and was making statement 'I was kidnapped'. Patient had said to his brother, 'I should just kill myself and be done with it.' Patient had refused to sign legal papers and cooperate with doctors in emergency room. Patient lives with his brother and has been in psych hospitals several times in the past 6 years due to non- compliance. Patient was in Madden 11.6.16 and has not been taking medications. Patient has poor insight and is guarded, labile, unpredictable and guarded. Patient refused to talk to writer and has been staying in his room. Patient is unable to make rational decisions and needs stabilization on medications for safety of self and others." The differential diagnoses are listed as "Mood Disorder, not otherwise specified, Bipolar Disorder Schizophrenia, and schizoaffective disorder". Nursing Progress Notes from admission state, "Completed initial nursing assessment. Body search and belongings check done. Oriented to Intake and admission process. Explained the admission papers and copies are given to the patient. Patient refused to sign papers despite all explanation and encouragement… Patient has been on restraints in ER. Per ambulance crew, patient was agitated and nonredirectable. Came in with restraints on for transportation and was removed by ambulance crew before admitting pt to the unit. Per ambulance crew, no elopement attempt noted."

A Nursing Admission Note entered on 11/21/16 at 3:00 a.m. states, "Completed initial nursing assessment. Body search and belonging check done. Oriented pt. to intake and admission process. Explained the admission papers and copies are given to the patient. Patient refused to sign admission papers despite all explanation and encouragement… patient has been on restraints in ER. Per ambulance crew, patient was agitated and unredirectable. Came in with restraints on for transportation and was removed by ambulance staff crew before admitting pt. to the unit…."

Entries into the Progress Notes for 11/21/16 at 3:30 a.m. state, "Administered Lorazepam 2 mg and Benadryl 50 mg IM [intramuscular] with Restriction of Rights for agitation at 3:25 a.m. Placed on 4 point restraints at 3:25 a.m. On admission to intake pt was uncooperative refusing body check and admission process. Verbal redirections given multiple times but unable to follow redirections. Patient got highly agitated and clenched fist and teeth grinding. While walking with patient out of the search room, pt attempted to hit the staff and spit on them." This entry was accompanied by a Restriction of Rights Notice completed on 11/21/16 at 3:23 a.m. It indicates that the recipient was placed in restraints and given emergency medication for the

following reason: “On admission pt was uncooperative, refusing body check, verbal redirections attempted multiple times, increasingly getting agitated with clenched fist and teeth grinding and while staff walking him out of the search room pt attempted to hit staff and spit on him.” The Notice indicates that the recipient was given a copy of the Notice and did not wish for anyone to be notified. All Code mandated documentation for restraint is included in the record.

A Unit Nurse Admission Note indicates that the recipient was admitted to a unit on 11/22/16 at 1:35 p.m.

Entries into the Progress Notes for 11/22/16 at 1:34 p.m. state, “Emergency medication Lorazepam 2 mg and Diphenhydramine 50 mg IM given at left gluteal muscle. Patient very combative and aggressive towards staff while receiving from intake. Verbally abusive, very angry, about to start physical fight with staff. Demanding to leave, not listening to verbal redirection. Combative and aggressive. Imminent danger to self and others.” This entry was accompanied by two Restriction of Rights Notices. The first of these indicates the recipient was placed in restraints and provides the following reason: “Pt is admitted on Emergency and displaying aggressive acting out behavior, pt is angry and requires ambulatory restraints to prevent harm to self and others.” The second Notice is for the administration of emergency medication and the reason is: “Patient is very combative and aggressive towards staff while receiving from intake. Verbally abusive, very angry and about to start a physical fight with staff. Demanding to leave. Not listening to verbal redirection. Lorazepam 2 mg Benadryl 50 mg given. Imminent danger to self and others.” Both of the Notices indicate that the recipient was given a copy of the Notice and both of them indicate that he wanted no one notified.

The record does not reflect an injury to the recipient or a complaint of an injury by the recipient. Also, this complaint was submitted to the Illinois Office of Inspector General for investigation and they reported it unfounded.

FACILITY REPRESENTATIVES’ RESPONSE

Facility representatives were interviewed about the complaint. They stated that the recipient had been uncooperative in Intake which escalated into his becoming aggressive and thus he was placed in restraints and given emergency medication. In both instances of restraint the record describes aggressive and dangerous behaviors which might reasonably necessitate this level of intervention. They also indicated that the recipient had never reported being thrown to the ground or injured by a security person and there is no Incident Report or examination by a physician, which would have been recorded if he had complained of injury. The HRA agreed that all documentation regarding restraint and emergency medication were in compliance with the Code. However, although this is not part of the stated complaint, the review of the record did reveal that although the recipient arrived at Intake at 3:00 a.m. on 11/21/16 in restraints from an emergency room, the Facesheet shows that he was admitted at 3:30 p.m. that day and then transported to the unit at 1:35 p.m. on 11/22. The HRA reminded staff that the recipient was being detained involuntarily from 3:00 a.m. onward and did not receive his psychiatric evaluation until 2:46 p.m. on the 22nd, nearly a day later. The HRA indicated that the Facesheet should reflect the time of the recipient’s arrival, because under the Code a certificate must be produced within 24 hours after he is detained or the recipient must be released. Hospital staff

reported that the time of the recipient's arrival is noted in all progress notes and assessments and that staff is always aware of the time limitations. They also reported that the Intake process can take longer when there are a number of recipients being processed at the same time.

STATUTES

The Mental Health and Developmental Disabilities Code states that: "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102 a). Adequate and humane services are described as "…services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others" (405 ILCS 5/1-101.2).

The Mental Health Code describes the requirements for the administration of psychotropic medication and its refusal:

"If the services include the administration of...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. .... 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 [to prevent harm]...." (405 ILCS 5/2-102 a-5).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services...must be informed of the recipient's right to refuse medication... The recipient...shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication... 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...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" (405 ILCS 5/2-107).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

FACILITY POLICY

Madden provided the policy and procedure for the refusal of psychotropic medication:

In compliance with the Illinois Mental Health and Developmental Disabilities Code and Department of Human services directives, an adult patient, or the patient's guardian of the person, if any, are to be given the opportunity to refuse generally accepted mental health

services, including but not limited to medication. If such services are refused, they are not be given unless such services are necessary, based upon the clinical judgment of an MD or RN, in order to prevent the patient from causing serious and imminent physical harm to self or others or are court ordered.…

Madden provided the policy and procedure for the administration of emergency medication:

1. If the administration of psychotropic medication is necessary to prevent the patient from causing serious and imminent physical harm to self and/or others, and there is insufficient time to give the patient, or his guardian of person, if any, the opportunity to discuss the advantages of receiving psychotropic medication, possible side effects or other known risks, alternative treatment and/or alternate medications or routes of administration and the possible consequences of the refusal, and/or to refuse psychotropic medication, the medication may be administered for up to 24 hours only after a physician order has been obtained.

2. As soon as possible but no later than 8 hours following the decision to administer psychotropic medication a Notice of Restricted Rights of Individuals form shall be completed and given to the patient. The circumstances leading up to the need for emergency treatment in the patient's record along with the rationale shall be documented by the physician who ordered the restriction of rights.

Madden provided the policy and procedure for Incident Reporting:

A. The Security Chief of Madden Mental Health Center shall serve as the Liaison to the Office of Inspector General (OIG).

B. Statements will be taken by one of MMHC's Approved Investigators from the alleged victim and all witnesses on the scene when an allegation of abuse or neglect has been reported.

C. In all cases of allegations of physical abuse RN will notify security to photograph the site of injury. Security will photograph the body part even if there is no apparent sign of injury. If patient refuses to cooperate RN will document in progress note. The photograph will be labeled with patient identification in accordance with security policy and procedures.

D. If OIG accepts a case for investigation, the original witness statements will be submitted to OIG along with the Incident Report Form and any other evidence such as labeled photographs.

E. If OIG does not accept a case for investigation, yet the hospital determines that further investigation is needed, the security Chief or his designee will conduct an internal investigation and document findings. Findings will be reviewed for approval by the Hospital Administration.…

CONCLUSION

The record shows that the recipient in this case was administered forced emergency medication on two occasions during this hospitalization. For both instances the record describes a level of dangerousness that might warrant emergency medication after less restrictive interventions were unsuccessful. Also, for both administrations the recipient was given a copy of the Restriction of Rights form and on both of these forms staff have noted that he wanted no one notified. There is no indication from the record or staff response that the recipient had reported being injured or thrown to the ground, a statement that would have generated an Incident Report and an assessment by a physician. The HRA does not substantiate the complaint that a recipient was administered forced emergency medication for no adequate reason, and that he was grabbed by the neck and thrown to the floor while in Intake.

SUGGESTION

1. Include the arrival time on the recipient Facesheet to ensure that the Code mandated timeframe for certification and psychiatric evaluation are adhered to.