FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
Case #17-110-9013
Choate Mental Health and Developmental Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Choate Mental Health and Developmental Center (Choate):

1. **Inappropriate restriction of rights of a patient for medication refusal.**

2. **Inadequate treatment by not allowing a patient to participate in treatment planning and not providing snacks per policy.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2 et al.)

Choate Mental Health and Developmental Center provides services to both persons with mental illness and persons with developmental disabilities. The allegations of this complaint involve a recipient housed on the mental health unit.

To investigate the allegations, an HRA team met with the recipient and representatives of Choate, examined the recipient's record with written consent, and reviewed pertinent policies and mandates related to admission.

FINDINGS

Interviews:

Recipient: The recipient was questioned about his treatment and he told the HRA that he feels that the Psychiatrist has him on too many medications because he is having trouble sleeping at night. He stated that he has not signed anything agreeing to take medications and that he has tried discussing with the prescribing Psychiatrist and when he does, he is told that if he does not take the medications he will be placed on 1:1 supervision. He also mentioned that he has been refused snacks because he has to see the Psychiatrist during snack time and then staff does not allow him to have a snack upon his return. Other than the medication issue, the recipient said he was doing well and he wanted to leave but the Psychiatrist “keeps him here”. He said that he just has clinical depression and disagreed with his other diagnoses.

Social Worker: The recipient's social worker provided some history of the recipient's admissions. In June, 2012 the recipient was transferred from a maximum security state operated facility to Choate. In March, 2016 he had a "failed discharge" to a community provider due to verbal aggression and "posturing." He was readmitted to Choate in April, 2016. He was on medication over objection (Court ordered) until January, 2017 but now he is voluntarily taking them. She stated that they just need to have verbal voluntary consent which is good for 1 year and no signature is required, but they do have to have a witness who can agree that the patient is agreeable to taking medication. The Psychiatrist had explained to him that if he refuses his seizure medication he would have to be placed on a medical 1:1 in case he had a seizure. She explained that he has grand mal seizures and his last one lasted for 2 hours. She said he does refuse to attend treatment meetings at times, but when he does, they typically go to his bedside and talk to him. He has recently refused labs but she was unaware of any medication refusal and said that there are no nursing notes reflecting that he has refused medications. The social worker did recall that recently he was placed on 1:1 for seizure protocol not for medication refusal. The recipient did speak to her about sleep medications recently and stated that he was having sleepless nights due to anxiety over a situation with his family and some money that he thought he had in an annuity that the family states he does not have. Social Security had recently appointed a payee for the recipient which he also does not like. When questioned about therapy sessions and snack time, the social worker explained that when patients have appointments with the Psychiatrist, he goes to the patients they do not come into his office. Therefore, there is no reason for the recipient to miss a snack in order to see the Psychiatrist. The therapist said the Psychiatrist sees the recipient weekly and writes monthly case notes unless he needs to write one sooner. The HRA also asked about discharge criteria and plans and was told that he is at the top of a waiting list for a community efficiency apartment with staff and 24 hour nursing which would be good for him due to his seizures.

Chart Review:

Treatment Plan: The recipient's annual review dated 4/6/17 documented his history of multiple hospitalizations beginning in 2009 which included 3 state operated facilities. He had been discharged from Choate to a community nursing home in March, 2016 and he returned to Choate after 37 days due to "becoming verbally aggressive and posturing." It was noted that the recipient has a history of denying his diagnosis of Schizoaffective Disorder and he had started refusing his medications and therefore his behaviors began escalating. His discharge criteria was listed as being able to understand the need for psychotropic medications and adhere to the medication administration prescribed; develop skills required to communicate in a positive manner with staff and peers; and, have his symptoms of mental health decrease to a point where he can reside in a less restrictive environment. His anticipated date of discharge was listed as 6/15/17. The plan noted that although he denies having a mental illness, he is medication compliant and has agreed to take medications and follow his treatment plan when he discharges. It was also noted, however, that he may require the "weighted influence of Court Ordered Outpatient Treatment for successful discharge outcomes." His objectives included actively participating as a member of his treatment team and to be active in the recovery process by attending treatment team meetings, signing consents for discharge planning and participating in the discharge planning process for 30 days. His treatment plan included meeting weekly with

his Psychiatrist so that the Psychiatrist could "assess for clear and reality based thought content…assess any adverse reactions or side effects from prescribed medications…provide education on the effects of substance use on physical and mental health…[Recipient] will meet with his psychiatrist weekly to discuss his progress and to make any changes in medication treatment as clinically indicated for treatment of his psychosis." He was also scheduled to meet with his therapist once a week. Nothing indicated a set day of the week or time of day that the recipient would meet with the Psychiatrist or therapist. The treatment plan documented that the recipient refused to attend this meeting. The HRA found no documentation that the team went to his room to speak with him since he had refused to attend the meeting.

Daily Schedule: The HRA reviewed the master schedule for the unit which showed snack times of 2:15-3:00 p.m. and 8:00–8:45 p.m. There are no set times for therapist sessions or Psychiatrist sessions but most of the groups are scheduled to end by 4:15 p.m. after that time recipients have free/leisure time, dinner, unit activities and relaxation time with the exception of 6:00-6:45 p.m. when certain classes are scheduled to meet.

Progress Notes: The Psychiatrist's special observation progress note dated 1/13/17 documented that the recipient made threats to the social worker and Psychiatrist that he would stop taking all of his medications. It was explained to him that if he stopped taking the medications he would place himself at risk for a withdrawal seizure and could fall down and hit his head risking injury and possibly death. The recipient "replied angrily" that he did not believe them and did not believe in Psychiatry and then threatened to file a complaint with the Office of Inspector General (OIG). The note documented a plan of beginning 1:1 observation for withdrawal seizure precautions and to continue to "gently explain importance of not abruptly discontinuing medications and working with doctor to taper off medications to avoid withdrawal seizure and withdrawal dyskinesia. Legal rights provided to [recipient.]" A 1/13/17 staff note at 2:00 p.m. documented that the recipient was placed on frequent observation for stating that he was not going to take his medications. The recipient was up and about on the unit and it was noted that he had not had any behaviors or seizures and that he had not yet refused any medications. However, there was a "potential for withdrawal seizures" and the plan was to continue him on frequent observation as ordered. Another staff shift note at 8:30 p.m. that same day documented that he had been pacing the hallway and writing complaint forms but he took his medication. It also documented that he was on frequent observation for *"potential for withdrawal seizures if pt refused meds and stops abruptly on own."* The plan was to continue frequent observation with every 15 minutes documentation. On 1/14/17 a nursing frequent observation note at 6:00 a.m. documented that he was in bed all shift with eyes closed, no aggression or agitation, and took his medications on evening shift without complaint. The plan was to continue frequent observation with 15 minute documentation. A nursing note at 4:54 p.m. documented that he was still threatening to refuse medication and at 9:45 p.m. it was documented that the frequent observation was continued as ordered but also documented that he had been agitated earlier that day and required medication to help him calm down. On 1/15/17 at 10:59 a.m. a Psychiatrist's note documented that he was medication compliant and was no longer at risk for withdrawal epileptic seizures and frequent observation was discontinued. A Psychiatrist's progress note dated 2/21/17 at 2:00 p.m. documented that the recipient was tolerating all of his psychiatric medications with no complaints of adverse side effects and was not experiencing auditory or visual hallucinations. However, it was noted that the recipient requested to have his Ativan

decreased as he needed more energy and less tiredness. The plan documented that the current medications would continue but the psychiatrist will decrease the Ativan to 0.5 mg bid. The next Psychiatrist's note dated 3/23/17 at 1:30 p.m. documented no adverse effects of medication but noted concern with weight gain. The plan was to continue all medications and educate on healthy living and eating and brisk walking on the unit. He refused to have lab work drawn and the plan was to continue to educate him on the importance of having that done. A nursing note dated 3/12/17 at 12:35 a.m. documented that the recipient requested something to help him sleep because he was nervous and couldn't relax. Ativan 2 mg was administered and it was reported an hour later that the medication was effective. A social work progress note dated 4/6/17 documented that the recipient stated *"I will agree to take my medication. No I don't want to sign, just a verbal consent"* The social worker also noted that at that time, he did not want changes to his treatment plan and was content with the groups and activities he was enrolled in. A nursing note dated 4/16/17 at 1:00 a.m. documented the recipient requesting something to help him sleep and noted that he had been in bed quiet but unable to sleep. 2 mg Ativan was administered and a follow up note at 2:00 a.m. noted that it was effective.

Medication Administration Record (MAR): The January 2017 MAR documented that Olanzapine (antipsychotic), Lorazepam (anxiety), Lamotrigine (anticonvulsant) were listed on the MAR as being court ordered; Sertraline (antidepressant), Levothyroxine (thyroid), Benztropine (treats Parkinson's disease), Docusate Sodium (stool softener) and Ferrous Gluconate (iron) were listed as regular medications that were taken daily. The February 2017 MAR showed the same regular and PRN (as needed) medications still listing Lamotrigine as being court ordered. The March 2017 MAR showed a decrease of .5 mg in Lorazepam and showed the Lamotrigine, Ativan and Benztropine as being court ordered. All other regular and PRN medications were the same as previous months. The April 2017 MAR was the same as the March MAR and listed Benztropine and Lamotrigine as being court ordered. None of the MARs indicated that any medication was ever refused by the recipient.

Petition and Order for Administration of Involuntary Treatment: The Petition filed by the treating psychiatrist documented that the recipient was refusing to take psychotropic medication once the current medication over objection expired and listed rationale for the needed order as follows: He was experiencing suffering due to being *"delusional, actively hallucinating, responding to internal stimuli, verbally aggressive, irritable, agitated and angry…is unable to be discharged into a less restrictive setting in the community…is a danger to others. He was re-admitted on 4/15/16 for threatening to kill patients and staff at the nursing home…says 'I will kill you and bring you to the ground!'…cursing, yelling, threatening staff, threatening peers, non-compliant, verbally aggressive, appears angry…responding to internal stimuli. On 6/17/16 was reciting a football game he watched years ago all by himself with an imaginary conversant…observed daily staring at the floor with back hunched forwards, just staring at floor and then talking or mumbling to himself… isolating himself in his room…ADL's are often poor and room care needs improvement."* The petition continued by stating that the recipient lacks the capacity to make a reasoned decision about the treatment offered, made statements that he does not have a mental illness and does not need regular psychotropic medications and the refusal of medications has resulted in suffering and deterioration on the inpatient leading to a prolonged hospitalization that would be unnecessary had the recipient been taking psychotropic

medications on a scheduled basis; no other less restrictive services had been demonstrated to be effective as per the petition.

The Order was signed by a judge and dated 8/23/16 and authorized involuntary treatment for 90 days. This Order authorized administration of Zyprexa, Ativan, Cogentin and Lamictal (Lamotrigine) and listed alternative medications as Prolixin, Invega, Invega Sustenna and Seroquel XR. On 11/9/16 another Petition for Administration of Psychotropic medication was filed and the hearing was set for 11/17/16, but then a Motion was filed to substitute the Judge followed by an Order granting the same. Also, on 11/17/16 a Motion was filed for an Independent Examination; the case was continued until 1/17/16, then continued until 3/2/17 and then a docket entry on 3/14/17 noted the "patient accepted meds."

Consent for medication was signed by the recipient on 4/15/16. He agreed to take Clonazepam for anxiety, Seroquel XR for psychosis and mood swings, Carbamazepine for mood swings, Sertraline for mood and Benztropine for EPS. On 1/10/17 the recipient gave verbal consent for Olanzapine, Ativan, Cogentin, Lamictal, Prolixin, Prolixin Decanoate, Invega and Invega Sustenna IM and Seroquel XR. This was documented by a signature from the prescribing clinician and his social worker signing as a witness and noting he gave verbal consent for the medications. The form stated that the medication information was discussed and that written information was provided to the recipient. Another consent to medication documented that the recipient gave verbal consent on 4/16/17 for medication but refused to sign the form. This form was signed by the prescribing clinician and witnessed by the social worker and indicated verbal consent was given by the recipient. The consent was for Lamotrigine, Olanzapine, Lorazepam, Sertraline, Benztropine, Prolixin, Prolixin deaconate, Invega Sustenna and Seroquel.

Restriction of Rights: The HRA reviewed the restriction of rights form dated 1/13/17 which stated that the recipient was being placed on "1:1 special observation per [psychiatrist's] order for seizure precautions." Also on 1/14/17 a level pass status note documented that the recipient's pass was reduced to "R" meaning he cannot leave the unit except for court or medical procedures. This pass reduction was a result of him being an imminent risk of harm to self. The specific behaviors documented were that he was showing agitation and stating he was not going to take his medications. He was placed on frequent observation for seizure precautions. This pass level note was signed by the Psychiatrist and another staff person.

Policy Review:

The Patient Handbook states that snack times are scheduled at approximately 2:15 p.m. daily. Patients are allowed to have their own non-perishable food items and soft drinks brought in by visitors or family providing they are store-bought, individual sized, pre-packaged and sealed. Items packaged in glass containers are not allowed. The policy continues to state that vending machines are also available during snack time for those without their own snack supply and states that the unit will provide a snack for individuals without resources. The policy also states that food trays for meals cannot be held for extended periods of time therefore, patients are encouraged to eat meals when they are provided. If a patient misses a meal the policy states that patients can speak with nursing staff and an alternative will be provided. However, the policy does not address missed snacks specifically.

Master Treatment Planning Policy: The treatment plan policy states that *"It shall be the policy of Choate Mental Health Center that a comprehensive, multi-disciplinary, integrated treatment plan shall be developed in written format for each individual admitted for services in order to outline a strategy for symptom alleviation, behavioral improvement, and enhancing quality of life. The strategy shall initially be called an Initial/Admission Treatment Plan, but ultimately becomes a Master Treatment Plan, which shall be developed in collaboration with the individual, family, guardian, or others as appropriate, and the multi-disciplinary treatment team... An inter-disciplinary approach shall be utilized for all treatment planning activities. The treatment team shall include at a minimum the Core Treatment Team which includes the patient, an RN, Social Worker, and Psychiatrist. Other disciplines, including but not limited to, Mental Health Technicians, Activity*
Therapists, Educators, Vocational Instructors, Psychologist, Speech and Hearing Specialists, or Medical Services staff may and should be included in the planning process, as appropriate to the individual patient."

Medication Administration/Consent policies: The HRA reviewed the Psychotropic Medication Risk/Benefit Counseling; Right of Refusal policy which states *"It shall be the policy of the Clyde L. Choate Mental Health Center to educate patients, or their guardians, about the safe and effective use of medication, including risks versus benefits, according to the law and their needs. Whenever a patient refuses physician recommended/-ordered psychotropic medication, a physician must determine if that patient meets criteria for emergency medication and/or court enforced involuntary medication, document that determination on a designated form,*
and clinically intervene accordingly. The results of all such assessments must be communicated to administration, who will record and report the information as requested by the Department of Human Services (DHS)… Counseling will be documented by the prescribing practitioner on the Consent to Medication, MR28, which will be filed in the patient's medical record in the consent section of the chart…The physician will indicate on the consent form that counseling has taken place and that the patient or guardian has received written information on each occasion that a new psychotropic medication is utilized as a prescribed part of the treatment plan. The consent form will be placed in the patient's medical record in the consent section of the chart…Should the patient or guardian exercise the right to refuse proposed psychotropic medications, none will be prescribed or administered and the patient/guardians rights will be respected by the practitioner and the clinical staff. 2. If after a medication has been initially approved by the patient or guardian, where applicable, and the patient or guardian later refuses the prescribed medication, the medication will not be given to the patient. Unless specific clinical evidence is available to support an override of the refusal, the medication will not be given."

The Informed Consent Medication policy requires consent for medication and states *"Prescribing practitioners shall obtain written informed consent each time a new psychotropic medication is prescribed and if they plan to exceed the dosage range for medications for which consent was previously obtained. Reaffirmation of the informed consent shall be obtained after one (1) year of initiation of medication and then every year in case medications are used for long periods of time. Consent to Medication (IL462-0012MA) and List of Medications (MR28) shall be used for obtaining informed consent. In no situation shall the patient be given medication*

over objection except when authorized involuntary medication administered under the provision explained in MSO.039….Exception to obtaining informed consent would include:
1. Events of life threatening emergencies.
2. Use of emergency medication pursuant to Section 2-107 of the Mental Health and Developmental Disability Code.
3. Use of medication by court order. When a patient is unable to make decisions about his/her care & treatment, and services, hospital involves a surrogate decision maker/guardian in making these decisions."

STATUTES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to *"adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The 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 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.2 A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act3 may not consent to the administration of electroconvulsive therapy or psychotropic medication. A surrogate may, however, petition for administration of such treatment pursuant to this Act...A qualified professional shall be responsible for overseeing the implementation of such plan."*

The Code (405 ILCS 5/2-107) provides for refusal of services: *"(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…(h) Whenever psychotropic medication or electroconvulsive therapy is refused pursuant to subsection (a) of this Section at least once that day, the physician shall determine and state in writing the reasons why the recipient did not meet the criteria for administration of medication or electroconvulsive therapy under subsection (a) and whether the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1 of this Code. If the physician determines that the recipient meets the standard for administration of psychotropic medication or electroconvulsive therapy under Section 2-107.1, the facility director or his or her designee shall petition the court for administration of psychotropic medication or electroconvulsive therapy pursuant to that Section unless the facility director or his or her designee states in writing in the recipient's record why the filing of such a petition is not warranted. This subsection (h) applies only to State-operated mental health facilities."

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:*
(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian…"

CONCLUSION

The complaint alleged inappropriate restriction of rights of a patient for medication refusal and inadequate treatment by not allowing a patient to participate in treatment planning and not providing snacks per policy. The recipient told the HRA that he had been informed that if he refused medication he would be placed on 1:1 observation. Upon investigation, the HRA learned that the recipient had refused medications in 2016 and an Order for Involuntary Treatment was signed in August but the 1:1 observation was not until January, 2017. The reason listed for 1:1 special observation was *"per [Psychiatrist's] order (seizure precautions.)"* The therapist informed the HRA that this recipient has grand mal seizures and his last one lasted for 2 hours. It was documented in several different places in the chart including the restriction of rights form that the recipient was placed on special observation or frequent observation due to withdrawal seizure precautions. The Psychiatrist was concerned that the recipient would abruptly stop the medication rather than tapering and could put himself at risk for withdrawal seizures. The enhanced supervision lasted approximately 2 days and then was removed once staff was sure that he was still taking medications and no seizures were noted. Since it was well documented that the increased supervision was for seizure precautions and not for refusing medication, this allegation is **unsubstantiated.**

The second allegation for inadequate treatment due to the recipient not being allowed to participate in his treatment planning was based on the Psychiatrist not considering the recipient's feedback regarding medication that he claimed was causing a side effect of him not being able to sleep at night. When the HRA spoke with the therapist, she did say that the recipient had told her he was having trouble sleeping at night and had requested medication to help him sleep,

however it was due to a family issue that was causing him stress and anxiety not due to prescription medication. The therapist documented this conversation accordingly and nursing notes also documented that was Ativan was administered when the recipient requested medication to help him sleep. The 2/21/17 case note from the Psychiatrist documented that the recipient requested to have his Ativan decreased as he needed more energy and less tiredness. The plan after that visit documented that the current medications would continue but the psychiatrist decreased the Ativan to 0.5 mg bid which showed that he did indeed consider the recipient's feedback regarding his medications. Therefore, this allegation is **unsubstantiated.** The following suggestions are offered.

- The therapist told the HRA that the Psychiatrist sees the recipient weekly and writes monthly case notes unless he needs to write one sooner. The HRA suggests that the Psychiatrist consider documenting every visit with patients to have more accurate and updated chart information.

- The therapist stated that they just need to have verbal voluntary consent for medication which is good for 1 year and that no signature is required just a witness verifying that the patient consented. When reviewing the policies regarding informed consent, the HRA did not find this practice in any of the policies it reviewed. Administration should review this practice and if it is an approved practice, the policies should be revised to reflect that, including the provision of medication education as well as medication alternatives. The HRA was concerned that this might leave the facility vulnerable if a patient says they did not consent and staff sign a form stating the patient verbally consented then it becomes one person's word against another's. The facility should consider involving a third party such as a family member as a witness to any verbal consents rather than staff persons.

- Ensure that MARs document medication refusals.

The final aspect of this complaint was that the recipient was being denied snacks because he was required to see his Psychiatrist at that time. The HRA reviewed a unit schedule which showed that snack time was around 2:15 daily. When reviewing case notes, the HRA found two Psychiatry notes at 1:30 and 2:00 p.m. which could possibly interfere with snack times. However, when we spoke with the therapist, she told the HRA that the Psychiatrist typically comes to the patients for appointments rather than the patients coming to his office. Therefore, there would be no reason why a patient should have to miss a snack time. No documentation was found indicating that the recipient missed or refused a snack or that he had requested to have a snack due to missing one for a Psychiatric appointment. When reviewing his treatment plan, it was noted that he was to meet with the therapist weekly and the Psychiatrist would provide weekly psychiatric monitoring, nothing indicated a set day of the week or time of day that the recipient would meet with the Psychiatrist or therapist. Therefore this portion of the second allegation is also **unsubstantiated.**

RESPONSE

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

IDHS
Bruce Rauner, Governor • James T. Dimas, Secretary

CLYDE L. CHOATE CENTER
1000 NORTH MAIN ST. ANNA, IL 62906

December 13, 2017

Mr. Paul Jones
Egyptian Regional Human Rights Authority
#7 Cottage Drive
Anna, IL 62906-1669

RE: HRA Case # 17-110-9013

Dear Mr. Jones,

It is noted that the findings on the allegation in this case is unsubstantiated but that there are suggestions from the HRA, as follows:

1). HRA suggests that the Psychiatrist consider documenting every visit with patients to have a more accurate and updated chart information.

2). Administration should review its practice regarding obtaining verbal voluntary consent for medication, and that polices be revised to reflect that practice, including the provision of medication education as well as medication alternatives. HRA further suggests the facility consider involving a third party such as a family member as a witness to any verbal consents rather than staff persons.

3). Ensure the MARs documents the medication refusals.

We appreciate the suggestions as they allow us the opportunity to improve upon the services we provide at Choate Mental Health. Attached is the response to your suggestions.

Sincerely,

Linda Parsons, Acting Hospital Administrator

cc: Bryant Davis

HRA Case # 17-110-9013
December 13, 2017

Finding/Recommendations/Suggestions	Response
1). HRA suggests that the Psychiatrist consider documenting every visit with patients to have a more accurate and updated chart information.	Standards require the psychiatrist to document weekly for the first 8 weeks and monthly thereafter as a minimum for documentation. Treatment planning meetings occur at 72 hours, 10 days and every 30 days after admission which also require documentation. Other meetings would be as needed and should be documented as well. Documentation guidelines and the HRA suggestions will be reviewed with providers.
2). Administration should review its practice regarding obtaining verbal voluntary consent for medication, and that polices be revised to reflect that practice, including the provision of medication education as well as medication alternatives. HRA further suggests the facility consider involving a third party such as a family member as a witness to any verbal consents rather than staff persons.	It is the policy of Choate Mental Health Center to educate the patient and/or their guardians about the safety and effectiveness of medications offered during their treatment. The education should include the target symptoms, risk vs. benefit, side effects, and alternatives of medication offered. Information is presented verbally and in writing. Psychotropic medication shall not be prescribed for a patient without informed consent by a prescribing practitioner. Practice allows for obtaining verbal consent with a witness signature. The facility will review the informed consent policy in regards to language for verbal consent. Other suggestions will be discussed with providers.
3). Ensure the MARs documents the medication refusals.	It is the policy of Choate Mental Health, if a medication is not administered, the reason is to be specified/documented on the MAR by the RN. A progress note should be written documenting the reason medication was not administered. Documentation of medication administration/refusal will be reviewed by the facility.