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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 20-100-9018
ELGIN MENTAL HEALTH CENTER

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the care provided to patients in the forensic treatment program at the Department of Human Services' Elgin Mental Health Center. Allegations are that emergency medications and restraints may be used in violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The hospital has a 390-bed capacity. At the time of this writing there were 297 forensic and 13 civil patients at the facility. 5 units are dedicated to those Unfit to Stand Trial (UST) and 6 units to those found Not Guilty by Reason of Insanity (NGRI), all of whom are subject to rights under Chapter II of the Mental Health Code. Most of these units have 25 beds with 1 assigned psychiatrist. An HRA team interviewed medical and nursing administrators and reviewed relevant program policies. Our sample included the masked records of 9 UST patients who received 6 or more days of emergency medications in January and February 2020. We also received court documentation that showed there were a total of 9 medication petitions filed by the facility in 2019 and a total of 7 medication petitions filed in 2020.

COMPLAINT SUMMARY

It was alleged that some UST patients at Elgin are given multiple emergency medications for numerous days without adequate need and without filed petitions, in patterns that intentionally avoid exceeding the Code's 72-hour limit and ultimately appearing in court. Some of these incidents reportedly include the use of restraints at the same time.

FINDINGS

Patient A received 18 emergency medication injections through January and February 2020: 1/2, 1/4, 1/6, 1/7, 1/11, 1/17, 1/21, 1/24, 1/27, 1/28, 1/29 (72 weekday hours), 2/5 2x, 2/7, 2/8, 2/13,

2/15, 2/19 and 2/29, all separate incidents as described in the documentation. A medication petition was filed on 1/21 and a court order was entered in the record on 2/7. According to the emergency medication progress notes, these injections were given for various acts of physical violence including attacks on peers, throwing objects, and threatening to kill or physically harm staff and peers while posturing in intent. Corresponding restriction notices included the same justifications and stated that the patient's preference for emergency intervention was used and that no one was to be notified. The patient was restrained in addition to receiving injections on 1/2, 1/6, 1/29, 2/5 and 2/15. On 1/2 the patient physically attacked three peers, was put in 4-point restraints at 11:55 a.m. and then received Haloperidol, Lorazepam and Diphenhydramine injections five minutes later for the exact incident per the record: "4pt FLR and given ROR meds" (full leather restraints and restriction of rights medications). There was no documented need for the medication to prevent serious and imminent physical harm once in restraints. The other instances seemed justified as the patient continued to physically struggle after initial medications or restraints.

Patient B received 6 emergency medication injections in January 2020: 1/16 2x, 1/17, 1/25, 1/26 and 1/30, all for separate incidents. According to a progress note and a restriction notice, the second injection on 1/16 was given after the patient took a peer's bible and would not give it back. Although the pair "almost got into a physical altercation but staff quickly intervened", the patient was still given injections after the situation was defused. On 1/17 the patient kept exposing himself and threw a chair at staff. The documentation stated that he would not calm down and was placed in restraints and then medicated when he continued to struggle. On 1/25 he was noted to be disruptive and agitated; he removed his clothes and masturbated in the dayroom. Security was called for assistance and the patient was medicated. There was no additional information to suggest a need to prevent serious and imminent physical harm and no less restrictive alternative was available. On 1/26 however, the patient carried on with the same behavior and his peers were getting angry with him, which created an unsafe situation per the record. Medications were given when the patient refused to stop, and restraints were not used in that instance. Restriction notices were completed in each case. The notices are conflicting, some stating that the patient had no emergency intervention preference, others that his preference was used, and some stated that although his preference was restraints, "administering emergency meds is less restrictive."

Patient C received 16 emergency medication injections in January and February 2020: 1/17, 1/19, 1/21, 1/23, 1/27, 1/29, 2/1, 2/2 (weekend), 2/3, 2/4, 2/5, 2/7, 2/8, 2/9 (weekend), 2/13 and 2/16, all for separate incidents. Progress notes and restriction notices referenced a variety of physically threatening behaviors including throwing objects, cursing at and threatening staff while posturing toward them, spitting at staff and peers, using racial slurs to provoke them, attempting to hit them and refusing to hand over a scarf from around her neck. Restraints were used in conjunction during some of the events, which by documentation seemed necessary for continued struggles. Restriction notices were completed for each instance and all stated that the patient had no emergency intervention preference and wished no one to be notified.

Patient D received 11 emergency medication injections in January 2020: 1/17, 1/19, 1/20 2x, 1/21 4x, 1/22 and 1/23 2x (exceeding 72 weekday hours), all for separate incidents. Reasons for the emergency injections or restraints included touching and taunting staff and peers, getting close to staff, wrapping his arm around a staff's neck, swinging at staff, kicking peers, and grabbing at

them aggressively. Restraints were used on 1/17, 1/19, 1/22 and 1/23, and the nursing entries referred to the patient's attempts to get out of them, being potentially harmful and needing medication. Except on 1/19, a restriction notice stated that while in Velcro restraints, the patient "continued to be verbally loud, threatening staff not able to calm down, very agitated and therefore medication given….", failing to explain how he threatened staff while restrained or suggest a need to prevent serious and imminent physical harm. Each incident carried a restriction notice that stated the patient had no preference for emergency intervention and no one was to be notified.

Patient E was given 7 emergency injections in January 2020: 1/3, 1/9, 1/19, 1/21, 1/27 2x and 1/30, all for separate incidents, which included being intrusive with peers, provoking them, going into their rooms and being verbally abusive, not able to be redirected. In every instance she was noted to have "muscles tense, fists clenched", except for a second emergency injection on 1/27 given for being "hyper verbal, refusing to go to her room, trying to use the phone on the porch…argumentative, difficult to redirect." There was no documented need to prevent serious and imminent physical harm. Physical holds were applied in every situation but no restraints. One progress note mentioned a filed medication petition in November 2019, but the record provided was unclear of the outcome. All incidents, except for the second one on 1/27, had accompanying restriction notices that said the patient had no intervention preference and that no one was to be notified.

Patient F had 6 emergency medications in February 2020: 2/14, 2/17, 2/18, 2/21, 2/23 and 2/25, none for the same incident. The injections were given for screaming at staff while posturing with intent to fight, slamming doors, pushing chairs, punching a peer, and calling the staff bitches while threatening to kill them. No restraints were used. A restriction notice was completed for each administration, and the patient had no preference for type of emergency intervention and wished no one to be notified.

Patient G received 12 emergency injections in January 2020: 1/10, 1/12, 1/16, 1/17, 1/18 (weekend) 1/20, 1/21, 1/22, 1/23 (exceeding a 72-hour period), 1/25, 1/26 and 1/27 (weekend), all for separate incidents. The medications were given for kicking, punching, throwing objects, getting close to staff, "muscles tense, fists clenched", threatening to beat staff and peers, grabbing things from peers, throwing food trays, urinating on the floor and then escalating on redirection and throwing punches at close range of peers among other provoking behaviors. A medication petition was not filed, due to the patient taking medication voluntarily according to one psychiatrist's progress note. Restriction notices were completed, each stating that the patient's preference for seclusion was considered inappropriate for the behaviors. There was no restraint use.

Patient H received 20 emergency medication injections in January and February 2020: 1/23, 1/24 2x, 1/26, 1/27, 1/29 2x, 2/1, 2/3 4x, 2/4 2x, 2/9, 2/10, 2/13, 2/14, 2/26 and 2/27, all for separate incidents. The medications and some restraints were applied after the patient threatened staff with fighting, "muscles tense, fists clenched", provoking peers, kicking, punching, yelling out threats to harm or kill staff, biting, throwing objects, spitting on staff and peers and slapping and scratching them. The patient was restrained and medicated on 1/24, 1/27, 1/29, 2/3, 2/4 and 2/10, and each intervention seemed to be necessary to prevent further harm when the patient continued to physically struggle as described in the chart. Restriction notices were completed for every

medication administration and restraint episode. There was no intervention preference and no one to be notified.

Patient I was given 41 emergency medication injections in January and February 2020: 1/14, 1/15, 1/17, 1/20, 1/21, 1/23, 1/24, 1/25, 1/26 (weekend), 1/27 3x, 1/28 2x, 1/29 (72 weekday hours), (1/30 restraints/no medications), 1/31, 2/1, 2/2 2x (weekend), 2/3 4x, 2/4 3x, 2/5, 2/6 2x, 2/7 (exceeding a 72-hour period), 2/8, 2/11, 2/14 2x, 2/16, 2/17, 2/20, 2/21, 2/23, 2/25 and 2/27, none for the same incident. Many of the behaviors cited were for invading boundaries, being in peers faces, jumping around them, banging on walls, "muscles tense, fists clenched", throwing objects, threatening to hit staff and peers, swinging at staff, shadow boxing, hitting, slapping, kicking, circling staff with stares, spitting on staff and peers, pushing peers, slamming doors, numerous attempts to attack staff and destroying property. The patient received emergency medications for 3 consecutive weekdays from 1/27 through 1/29, and on 1/30 she was placed in ambulatory restraints for the entire day, received no medications and the emergency injections resumed on 1/31 through 2/8. Daily emergency administrations between 2/3 and 2/7 exceeded the 72-hour limit to file a petition, which the court file and patient record provided no evidence of. Many of the interventions included restraints and medications, most of which seemed to be appropriate to prevent physical harm, except a dose on 2/3 at 10:42 a.m., while restrained the patient received injections for "continues to be verbally aggressive, not redirectable, imminent risk of harm to others" according to the restriction notice; no supportive documentation of the need to prevent serious and imminent physical harm. All restriction notices were completed. The patient's preference for medication was used and she wished no one to be notified.

The HRA interviewed medical and nursing administrators about the use of emergency medications, restraints, and medication petition filing. They explained that all patients are asked for their emergency intervention preferences at the beginning of services and at the time of a restriction. Any designation is listed on a personal safety plan. Other intervention methods are to be considered besides medications, including the patient's preference, if any. The staff, understandably, could not speak into the specific incidents from the record sample but said that it is common practice to restrain and give medications although usually for a continued prevention of physical harm, which should be adequately documented. The Medical Director was also unable to account for the reasons why petitions were missed in these cases or why the facility psychiatrists choose not to file petitions after so many emergency administrations but said that mental health court has very strict rules and that sometimes petitions are sent back. She also assured us that it was not facility practice to intentionally skip a day of medication to avoid filing and going to court, in reference to Patient I's case. The treating psychiatrist in that situation was no longer employed at Elgin MHC at the time of the interviews. The Medical Director said that training for physicians on the use of emergency medications occurs annually in June.

CONCLUSION

Elgin Mental Health Center's policy (PPM 1740) Medication Refusal, Emergency and PRN Medication states that the rationale for administering emergency medication shall be documented in the record. The rationale is to specify the reasons the medication is necessary to prevent serious and imminent physical harm and shall include alternatives considered. A

restriction notice must be completed and entered in the chart. Emergency medications may be initially ordered for 24 hours, if the physician determines need, and another 24 hours may be authorized. The use of emergency medication is limited to 3 consecutive days, excluding weekends/holidays, unless a petition has been filed and the medication continues to be necessary to prevent serious and imminent physical harm. Department Program Directives (02.02.06.030) permit restraint use only when there is a clear and present danger of harm. Restraints may not be used to coerce, discipline, or punish a patient nor be used for staff convenience.

All reviewed policies are consistent with Code requirements, including, in summary, the use of emergency medications only for the need to prevent serious and imminent physical harm and no less restrictive alternative is available and may not exceed a period in excess of 72 hours, excluding weekends and holidays, unless a petition is filed and the need to prevent serious and imminent physical harm continues to be necessary (405 ILCS 5/2-107). Restraints may be employed as a therapeutic measure to prevent physical harm and not for coercion, discipline, or staff convenience (405 ILCS 5/2-108). A restriction notice must be completed with every emergency medication administration and restraint application (405 ILCS 5/2-201).

Substantiated policy and Code violations are found in the following instances:

Patient A: On 1/2 the patient was restrained for appropriate reasons according to the documentation but received an emergency injection once in restraints without a supportive need to prevent serious and imminent physical harm.

Patient B: On 1/16 the patient almost got into an altercation with a peer. Staff were able to intervene and prevent an emergency, yet the patient still received an emergency injection. On 1/25 the patient was given an emergency injection for masturbating and not following directives to stop, which, however inappropriate, was not necessary to prevent serious and imminent physical harm.

Patient D: This patient received emergency medications that exceeded a 72-hour period from 1/20 through 1/23 without a petition being filed, according to the record provided. And, on 1/19, the patient was given an emergency injection for being loud, agitated and threatening, although it is hard to imagine how the patient was threatening while in restraints without more supportive documentation.

Patient E: On 1/27 the patient got an emergency injection for being hyperverbal and argumentative when trying to use a phone on the porch, which is not a need to prevent serious and imminent physical harm, and there was no accompanying restriction notice according to the record provided.

Patient G: This patient also received emergency medications that exceeded a 72-hour period between 1/20 and 1/23, without a petition being filed. Although one psychiatrist wrote that the patient was taking medications voluntarily, the patient's right to refuse these emergency medications was being restricted and filing requirements under 2-107 still apply should the medications continue.

Patient I: After 7 consecutive days of emergency medications, including a weekend, this patient's medications stopped at the 72-hour weekday mark on 1/30, during which time the patient was kept

in restraints, and then the emergency medications resumed the next day on 1/31 and carried on for multiple days. The HRA must consider this an intentional evasion of 2-107 filing mandates and the patient's right to legal representation for unwanted treatment. In addition, daily emergency medication from 2/3 through 2/7 exceeded the 72-hour requirement to file, and the medications went on for weeks.

Recommendations

1. Elgin MHC must closely monitor emergency medication use and filing statuses. Complete and updated audit on similar cases.

2. Ensure that no physician's treatment course intentionally avoids strict statutory requirements under 405 ILCS 5/2-107.

3. Retrain medical and nursing staff on 2-107 requirements and ensure that annual training pursuant to 2-107 (i) include medical and nursing staff and is completed annually.

4. Ensure that emergency medications are only given to prevent serious and imminent physical harm as per the Code and policy. Review the practice of giving emergency medications when patients are already restrained. Ensure the provision of restriction notices when emergency medication is administered.

Suggestions

The phrase, "muscles tense, fists clenched" was repeated, over and over, within these records when documenting the need for emergency medications or restraints. The HRA understands that this type of behaviorally descriptive language is preferred but wonders about authenticity if being used systematically. This reminder should be included in training.

A number of the restriction notices conflicted on what a patient's emergency intervention preference was and whether it was used. One nurse wrote that a patient's preference for restraints was not used because, "medication is less restrictive". A patient's designated preference must be noted on the respective treatment plan and be *considered* for use when the need arises (405 ILCS 5/2-102a; 2-200). It is the patient's preference to be considered, not a nurse's, and this process should also be included in training.

All the records included medication progress notes that detail rationales for emergency medication use and track 72-hours periods and whether petitions have been filed—that portion was often left incomplete. Policy PPM 1740 refers to completion of another form (DOC-0012) that also tracks medication refusals and filed petitions, likely to satisfy requirements under Section 2-107 (h) of the MH Code. This form was not included in the records although we did not specifically request them. Elgin MHC is encouraged to review these forms and include them in audits to assure they are completed appropriately and consistently to avoid missing required filings.

RESPONSE

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

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

Elgin Mental Health Center
750 South State Street ● Elgin, IL 60123

Ms. Mariah Balaban
Human Rights Authority
9511 Harrison Street, W-335
Des Plaines, IL 60016-1565

HRA# 20-100-9018 May 12, 2021

Dear Ms. Balaban:

Thank you for your letter regarding your findings. Elgin Mental Health Center agrees that your recommendations would be beneficial for the facility in our goal for constant improvement. We appreciate that HRA found our policies to be consistent with code requirements. Therefore, EMHC has instituted changes to our procedure to ensure that all instances of the use of emergency medication are following facility policy.

Regarding recommendation 1, 2 and 4, Elgin MHC has instituted a process for all instances of the use of emergency medication to go through a review and audit by the medical director's office to ensure that the emergency medication use is appropriate and following policy. This review process provides coaching and direction to physicians and nurses to ensure that each instance of emergency medication use is monitored closely, follows strict statutory requirements, and that it is only given to prevent serious and imminent physical harm. Additionally, this review improves documentation.

Regarding recommendation 3, EMHC engaged in a training of all physicians on April 16, 2021 with the Kane County Assistant States Attorney to retrain on completing emergency medication petitions in a timely and accurate manner. Additionally, they participated in a retraining on the use of emergency medication during the April 2021 Medical Staff Organization meeting. Nursing staff will be retrained on emergency medication within the next 30 days. All physicians and nurses complete an annual training entitled MH-81 Emergency Medication Management each year and will continue to do so.

Please feel free to include our response with any public release of your Report of Findings.

Respectfully,

Michelle Evans, DSW
Hospital Administrator