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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 22-100-9008
LAKE BEHAVIORAL HOSPITAL

Introduction

On December 7, 2021 the North Suburban Regional Human Rights Authority opened an investigation into a complaint about services provided to a recipient of services in Lake Behavioral Hospital. Substantiated findings would violate rights protected under the Illinois Mental Health and Developmental Disabilities Code (405 ILCS 5).

The specific complaints under investigation are:

1) **Alleged violation of 405 ILCS 5/2-102:**
   - Recipient was repeatedly physically assaulted by other recipients without any intervention from the provider
   - The provider did not allow the recipient to receive treatment for his diverticulitis symptoms or to contact his own doctor.
2) **Alleged violation of 405 ILCS 5/2-103a:**
   - The provider violated the recipient's communication rights by restricting the recipient to one phone call per day, which was timed and monitored.
3) **Alleged violation of 405 ILCS 5/2-107:**
   - The provider incorrectly administered emergency psychotropic medication
4) **Alleged violation of 405 ILCS 5/2-113a:**
   - The provider did not appropriately contact the recipient's designated family member regarding admission or treatment.
5) **Alleged violation of 405 ILCS 5/2-200**
   - The provider ignored the recipient's requests for transfer to a different facility.
   - Patient Rights were not posted on unit.
6) **Alleged violation of 405 ILCS 5/3-400:**
   - The provider did not assess for the capacity of the recipient or provide intake/discharge rights upon voluntary admission

Lake Behavioral Hospital (LBH) is a 146-bed state-of-the-art hospital offering inpatient and outpatient mental health and substance use treatment for adolescents, adults, and senior adults. LBH has been operational since March 2018. At the time of the services being investigated in this report, LBH was in its old facility on a floor of Vista Medical Center East, with 46 beds in their adult inpatient unit. The North Suburban Human Rights Authority thanks the administration of Lake Behavioral Hospital for their full cooperation in this investigation. This team impressed the

HRA with its openness to collaboration, growth mindset, and clear dedication to continuous quality improvement.

Method of Investigation

To proceed with this investigation, the HRA reviewed the recipient's clinical record (with authorization) from Lake Behavioral Hospital (LBH). The HRA obtained additional case information through a conversation with LBH doctors and the hospital risk manager. The HRA also reviewed relevant LBH policies provided by the hospital.

Case Summary

The recipient of services was admitted as a voluntary patient to the hospital on October 26th and discharged on November 4th. The record contains a completed Application for Voluntary Admission, which was signed by the patient and checked to indicate that he "wish[ed] no one notified" of his admission. The application was signed by an intake worker to indicate that the recipient was "given a copy of the rights and had the capacity to understand them." An explanation of rights form in the record also has the recipient's signature on it to indicate that he had received a written explanation of his rights as a voluntary admittee. Despite this documentation to show the patient voluntarily admitted himself and was aware of his rights, a psychosocial assessment from admission notes *". . .patient reported he doesn't know why he was admitted. Patient reported it might be that his parents wanted some space from him."* A therapy assessment completed on October 27th documents the patient reported he *"felt forced here by parents."*

An intake assessment from the record indicates that the recipient has no legal guardian and lives with his mother and stepfather. The recipient's Admission Medical History records indicate the past medical history as: "Hypertension, Asthma, ADHD, Low Testosterone, water retention." There is no mention anywhere in the record that the recipient was suffering from diverticulitis. The hospital administration asked current medical and psychiatric physicians if the recipient had ever made a complaint about diverticulitis symptoms, and staff reported that they were unaware of these complaints.

The record shows that the recipient had requested to be transferred from Lake Behavioral Hospital as soon as possible, but that the transfer request could not be accommodated. A note from October 29th indicates, *"Patient reported he wanted to be transferred to [transfer] hospital as soon as possible."* A note from later that day indicates: *"This writer began patient's request to transfer and was notified by 7:30pm that [transfer] hospital was unable to accommodate the request."* A note in the record from October 30th indicates*: "This writer met with patient to inform [him] that [transfer] hospital stated they were unable to accommodate the patient . . ."*

On October 29th at 12:45pm, the recipient signed a release of information (ROI) allowing the provider to contact his mother. The record and HRA interview confirm that a social worker called the recipient's mother and left voicemail messages for her at 12:54pm and again at 4:37pm that day. A note in the record from October 30th indicates that the hospital social worker notified the recipient she had tried to call his mother and had left two voicemails. The recipient then asked the social worker to contact his stepfather and provided a signed release of information for that

purpose. The stepfather was called on October 30th. Family contact appears to have been established after this date and according to the record on November 3rd the recipient's parents met with him and his social worker for discharge planning.

The record does not contain any documentation of repeated physical assault by the recipient's peers. The hospital told the HRA in the interview that this recipient had been involved in negative peer interactions throughout his stay, for example, inserting himself into other patients' altercations or "shaking patients in the day room". The HRA could not find examples of these behaviors in the record, which seems to document only one incident of physical violence, which occurred the morning of October 31st: *"[recipient's] roommate apparently was sleeping in his bed and [recipient] tried to forcefully move his roommate from his bed. His roommate then woke up, turned, and punched [recipient] in the face."*

A nursing progress note from November 1st about the same incident indicates: *"PT wanted to go to the hospital, Nurse practitioner came and assessed him. Pt was throwing up and dry heaving. Pt stated "I want to go to the ER so that I can go home afterward. . . Pt stated he was hit. Nurse assessed him. Pt denied symptoms such as headaches, blurry vision, and dizziness"*

None of the provider staff interviewed by the HRA were present or remembered the incident, and there was no other mention of this incident in the record. The hospital administrator told the HRA during the interview that *"Staff responded immediately to the commotion when it occurred, but both patients allegedly denied any physical altercation had occurred at that time . . . this patient shook their roommate from a deep sleep to wake up, and the roommate struck him in the head as a reflex [not intentionally]."*

According to the hospital administrator the recipient never addressed this as an "incident" with the RN staff. Instead, he told his mother who then reported it to the nursing staff, who then completed an incident report after the fact. The incident report was not available to the HRA because the provider keeps incident reports only for internal risk assessment. The hospital administrator sent the HRA a paraphrased description of the reported incident with the follow-up: "*The roommate was moved to an adjacent unit, and the patients were separated. Medical evaluation was conducted immediately by RN Staff, and the patient was seen by medical services to ensure medical concerns were addressed."*

Regarding emergency medication administration, the record contains two examples: a doctor's note from October 31st indicates: **"**. . . *pt was given Benadryl, Haldol, and Ativan . . . IM injection to prevent PT from causing imminent harm to himself or others.*" A nurse's note from 11/2/21 indicates: *"Pt became agitated and received Benadryl 50mg and Haldol 5mgim. Patient took medication willingly. Patient has increased agitation, unable to be redirected."* The record contained no further documentation of these administrations, which were also not documented as rights restrictions.

Regarding the allegations of phone restrictions, the staff told the HRA in the interview that the recipient was never placed on any phone monitoring or restrictions. The hospital's Open Adult Patient phone times are daily from 11am-12pm and 6pm-6:45pm, and the hospital administrator

told the HRA that recipients have "24/7" access to use a phone to call attorneys or outside providers, and given additional privacy for these requests as needed.

The administrators explained to the HRA in the interview that the IGAC/HRA contact information, patient rights under the Mental Health Code, and HIPAA rights are posted prominently on each of the units in enlarged framed posters (4'x6'). The hospital administrator later confirmed that these posters were installed in June 2020 prior to the move to the hospital's current facility.

Policy Review

The HRA reviewed Lake Behavioral Hospital policies and procedures. The HRA found the hospital's Incident Reporting, Patient's Rights Restrictions, Documentation, and Administration of Psychotropic Medication Against the Patient's will in Emergency Situations policies were aligned with relevant codes and statutes.

The HRA found the Informed Consent for Medication policy to be slightly mis-aligned with relevant codes and statutes. This policy indicates: *"Psychoactive mediations may not be administered . . . without informed consent . . . except in* ***an emergency or a situation which*** *. . .* ***indicates the possible of immediate physical deterioration of the patient****.* This policy should not use *"emergency"* as a criteria for medication without consent, without defining "emergency". This policy also incorrectly indicates that prevention of "*immediate physical deterioration of the patient"* is a criterion for emergency medication administration, however it is not. The Mental Health Code states: *"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."* (405 ILCS 5/2-107 a)

Findings

This investigation found evidence to ***substantiate*** a provider violation of 405 ILCS 5/2-107: *provider incorrectly administered emergency psychotropic medication.* The following allegations of violations are ***unsubstantiated***:

1) **405 ILCS 5/2-102:**
   - Recipient was repeatedly physically assaulted by other recipients without any intervention from the provider.
   - The provider did not allow the recipient to receive treatment for his diverticulitis symptoms or to contact his own doctor.
2) **405 ILCS 5/2-103a:**
   - The provider violated the recipient's communication rights by restricting the recipient to one phone call per day, which was timed and monitored.
3) **405 ILCS 5/2-113a:**
   - The provider did not appropriately contact the recipient's designated family member regarding admission or treatment.
4) **405 ILCS 5/2-200**
   - The provider ignored the recipient's requests for transfer to a different facility.
   - Patient Rights were not posted on unit.

5) 405 ILCS 5/3-400:

- The provider did not assess for the capacity of the recipient or provide intake/discharge rights upon voluntary admission

Analysis

This investigation found evidence that Lake Behavioral Hospital violated 405 ILCS 5/2-107a when they administered the recipient at least two instances of emergency treatment, "*which 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.*"

During the interview with LBH staff the HRA discussed the administration of emergency medication and the standard for documenting "serious and imminent physical harm". The record must depict an appropriate need under 405 ILCS 5/2-107a, and not suffice to anything less, such as a description of "increased agitation" which may be a common symptom of mental illness and, without further description, does not necessarily rise to the standard set by the Mental Health Code. The HRA also discussed the note in the record from November 2nd that the recipient took an injection "willingly". This is not an indication of actual consent for medication unless the recipient was given the opportunity to refuse the medication and demonstrate that they are not a potential serious and imminent physical danger to themselves or others. The provider did not demonstrate to the HRA that in either of these situations the recipient was given the opportunity to refuse medication and to be de-escalated through their preferred method of emergency intervention, which in this case was not an emergency injection.

This investigation did not find evidence to suggest that the provider violated the recipient's voluntary intake rights. Although the complaint originally stated that the recipient's capacity for decision making was highly related to his psychiatric symptoms, the record demonstrated that the provider appropriately assessed for decisional capacity at the time of the voluntary application and also made a number of good faith efforts to explain the recipient's situation and rights to him.

Recommendations

1) Revise Lake Behavioral Hospital's Informed Consent for Medication policy to be better aligned with 405 ILCS 5/2-107 a – provide HRA with proof of revised policy.
    a. This policy should define "emergency", and should not indicate that prevention of "immediate physical deterioration of the patient" is a criterion for emergency medication administration

2) Re-train relevant staff on appropriate use of emergency medication and the standard for documenting "serious and imminent physical harm"
    a. Provide the HRA with proof of training

Suggestions

Although this investigation did not find evidence of the recipient's telephone rights being restricted, Lake Behavioral Hospital's phone hours restrict phone use to just one hour and 45

minutes per day, which the HRA believes does not rise to the standard of *"reasonable access"* set by the Code. (*"The facility director shall ensure that . . . telephones are reasonably accessible. . . (*405 ILCS 5/2-103)) the HRA suggests increasing the Open Adult patient phone time to at least four hours per day. (Revised phone times were also recommended by the report of findings for HRA case #20-100-9010.) The HRA also suggests adding the documentation of incident reports and related precipitating events and follow up to the hospital's Documentation Policy.