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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

Report 25-050-9009
LINCOLN PRAIRIE BEHAVIORAL HEALTH CENTER

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the care of a minor at Lincoln Prairie Behavioral Health Center in Springfield. Allegations were that the patient's hospitalization was prolonged due to inadequate assessments, discharge rights were not explained to the patient or parent, and they were not given opportunities to exercise them. It was further alleged that the patient was given the wrong medications. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Lincoln Prairie provides psychiatric care to children and adolescents from age 3 but primarily from ages 7 to 17. The hospital has a 97-bed capacity, and the average length of stay is 11-14 days. The HRA visited the facility where the issues were discussed with staff persons identified in the complaint, representatives from nursing and intake, and an attorney. Relevant program policies were reviewed as were sections of the patient's record with authorization.

Complaint Summary

It was reported that the 16-year-old patient should have been discharged sooner as his parent requested if not for inadequate assessments by a nurse practitioner who approached the boy for one minute with the same few questions, once while he was on the phone with his mother, once while he was having lunch and once over a zoom call. He insisted he was not suicidal each time, yet the nurse's notes were contradictory, and the patient was kept longer than necessary. The complaint states that the patient was finally discharged when the CEO intervened and overruled the continued hospitalization. The parent allegedly made several requests for discharge in the meantime but was never given a request form nor were discharge rights ever explained to her. It was also reported that the patient was given three pills one morning that were not his: one white, one green and one orange.

FINDINGS

An application by an adult for admission of a minor was completed by the patient's mother on November 20, 2024. The assessment and referral counselor who handled the admission entered the mother's signature and a "v" for verbal, meaning the admission document was not done in person. The counselor also verified by her own signature that she explained the rights contained on the form, including the right of the parent to request discharge, and had given a copy to the applicant and the minor as well as an explanation and copy of the rights of individuals. The rights of individuals form however, was only covered with the patient according to the signatures. Other forms completed verbally with the parent included an 18-point statement of patient rights, a 4-page conditions of admission, a guardianship acknowledgment and a consent for medical screening, a conditions for personal property, and a certification for homebound/hospital tutoring, each containing verification by a second witness signature at 12:55 pm.

An intake assessment showed the patient's admission to occur at 1:40 pm, accompanied by "self". He presented with self-injurious and suicidal thoughts and/or behaviors, cutting on his thigh and overdosing on Benadryl and Doxycycline two days earlier. The counselor found admission appropriate as did a psychiatrist who followed up with an examination to continue hospitalization on the following morning.

The HRA was unable to interview the assessment and referral counselor since she was no longer employed at Lincoln Prairie, so the division director filled in after reviewing the record. He said that the patient came from another hospital's intensive care unit via ambulance and that information and consents were covered with his mother over the phone. He could neither confirm nor deny from the record whether the mother was with the patient on arrival and said it was not something noted in their system. He described a long list of admission related documents, consents, rights, insurance information and various acknowledgments they go over with patients and guardians/parents during the admission process, which typically takes about 30 minutes to complete. He said that up to 90% of their patients arrive without guardians/parents and much of the required paperwork is done with parents over the phone. The right to request a 5-day discharge by signing a form is included. He explained that if a patient is over 12 years of age, they will handle the admission process including the same explanations and documents alone with them, and once completed they can call the parents back in if they are present. They will mail copies of admission documents and rights to parents if requested. We asked the attorney to look into whether there was more specific information in the record about who may have accompanied the patient on arrival, but he found nothing and said there was no indication that the mother was there.

The HRA followed up with the patient's mother who said she rode to Lincoln Prairie in the ambulance with her son, and her husband and the patient's Godmother followed behind them. She gave "a lot of information over the phone while in the ambulance", and the call took 16 minutes. She was able to identify the ambulance service and show mobile phone logs with a 16-minute call to Lincoln Prairie during the time of the transfer. They sat in the waiting room with the patient until he was taken back to complete his paperwork and given clothes to wear. She was not permitted to go with him, the staff saying he had to do it alone. She did not get a copy

of the admission application nor the rights of individuals and did not hear an explanation of discharge rights.

Individual/Family therapy notes by the patient's therapist from Nov. 21 state that the patient denied suicidal ideation, and a family zoom session was set for Nov. 25; the plan was to continue to monitor for suicidal ideation and self-injurious behavior. A psychiatry progress note from the 23rd described the patient as easily upset; he continued to have some suicidal ideations, "especially towards the end of the day. It is decreasing in frequency." The plan was to continue to monitor for suicide precaution. In another psychiatric note from the 24th written by the nurse practitioner, "Upon arrival, the patient was asleep in the group room. He stated his mood is 'tired'. He denies suicidal ideation, hallucinations…. The patient's suicidal ideations are decreasing. Today, the patient's Prozac dose was increased to 10mg by mouth daily for depressive and anxious symptoms." The justification for continued stay was to monitor for suicide precaution and the endorsement of suicidal ideation which were noted to be decreasing. According to subsequent daily entries, the therapist noted on the 25th that the patient denied suicidal ideations that day, that there was no targeted discharge date and that the continued stay was to monitor for suicidal thoughts, safety and integration of coping skills. The nurse practitioner wrote on the same day that she reviewed the patient's chart, discussed progress with his treatment team and saw the patient during his lunch. He denied homicidal ideation, except "The patient has suicidal ideation, but the frequency of his suicidal ideations are decreasing. Based on my clinical and professional assessment, if the patient was not hospitalized, he would act on his suicidal ideations. Today the patient will be started on Atarax 10 mg up to one time a day as needed for anxiety symptoms." Again, the plan was to continue to monitor for suicide precaution. On the 26th the nurse wrote that if the patient's suicidal ideations continued to decrease the anticipated discharge would be on the 28th. She referenced however that the patient's mother demanded he be discharged on the 26th or 27th, and she was advised by the nurse, therapist, clinical director and nursing director about the importance of ensuring the patient's safety and monitoring for medication changes. Per the note, the mother refused to acknowledge understanding and threatened to bring law enforcement to discharge her son by the next day. The mother was informed on the next day that due to the start of new medications the patient would need to stay until the 28th. The mother threatened to bring the police if the patient was not discharged. On the 27th, the chief clinical officer met with the patient and performed her own assessment where he denied any current suicidal ideation. He told her he had none since he arrived. They discussed his depression, medications, the need to take them and aftercare safety plans. The clinician found the patient motivated and positive and noted that discharge paperwork had been completed for the next day. Discharge occurred on the 27th, and according to the nurse practitioner's discharge summary, "The patient's mother extensively threatened staff…over the course of 2 days. Under the recommendation of administration, the patient was discharged by another nurse practitioner."

We were unable to interview the therapist since she was no longer employed at Lincoln Prairie but spoke with the nurse practitioner. She denied taking only one minute to assess the patient and explained that she rather takes about 20-30 minutes, at least 10-15 of which are face time and then there is a review of various notes from the previous 24 hours. These assessments are typically done 5-7 days per week. She asks if they experience medication side effects, if they are homicidal or suicidal, if they experience nightmares and asks about their sleep patterns and

appetite. She recalled meeting with this patient once while he was having lunch but said she took him to a private area to complete her assessment, she had conducted video assessments that lasted 15-20 minutes but did not recall a situation where she met with him while he was on the phone. The HRA inquired about differences in the therapist's notes that referred to the patient having no suicidal ideation and hers that stated he did have them but were decreasing. She said she met with him first thing in the mornings, and he would talk about overthinking the night before causing suicidal ideation. He frequently asked for as needed Hydroxyzine to help with falling asleep, which she added for bedtime. She told us that overall, during the day the patient was fine and her concerns and resulting notes were based on his evenings. Regarding his discharge, the nurse said that she wanted him to stay until the 28th to monitor him overnight and have one more dose of Hydroxyzine. Another practitioner assessed him and found no concerns for suicidal ideation after his mother made her demands for discharge. And regarding her progress note from the 26th where the mother demanded her son be discharged that or the next day, she said she offered to give the mother a 5-day (discharge request) form to sign and she refused saying she was calling the police.

The chief clinician was interviewed as well, and she denied intervening on behalf of the CEO. Instead, she said that the therapist expressed issues with the family who was threatening legal action if the patient was not discharged, and the therapist was going away for the holiday, so she conducted the assessment on the 27th. She found no reason to continue the hospitalization- he had no suicidal ideation and had a safety plan in place.

On the alleged wrong medication issue, the nursing director told us that he never heard this complaint although there was some back and forth about the parent's consent for medications, not that wrong medications, one white, one green and one orange were given. He said the Prozac that the patient was taking is green and orange, and the Hydroxyzine that was added is white. The attorney followed up with a nurse who was identified in the complaint to have received the error complaint, and that nurse said he had found no evidence of medication errors and therefore no reason to report an incident.

CONCLUSIONS

The patient's hospitalization was prolonged due to inadequate assessments-

Hospital policy (PC-280) states that individual therapies shall occur no less than once weekly and be focused on individually identified problems. Assessment documentation will include ongoing issues related to discharge planning. Policy (PC-269) refers to active treatment that is provided daily as developed by the treatment team, and progress notes must include progress towards treatment plan goals.

Under the Mental Health Code, "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 5/2-102a). Adequate and humane care and services are defined as those "…reasonably calculated to result in a significant improvement of the condition of a

recipient of services confined in an inpatient mental health facility so that he or she may be released…." (405 ILCS 5/1-101.2).

Each assessment whether by the therapist or nurse practitioner, referred to the need for ongoing monitoring to ensure safety. The nurse's progress notes cited decreases in suicidal ideations, which she explained were based on her concerns for the patient's condition at night and for observations after medications were introduced or increased, however we think her position could have been made clearer in the documentation. But there is no evidence to suggest that assessments were inadequately conducted in one minute, only that members of the treatment team were trying to ensure the patient's safety before discharge, which is what psychiatric hospitals do. A rights violation is <u>not substantiated</u>.

Discharge rights were not explained to the patient or parent, and they were not given opportunities to exercise them-

Hospital Patient Rights policy (RI-100) states that patients and legal guardians shall be provided, with explanation, a list of rights and responsibilities at the time of admission that includes the rights of individuals. Policy on verbal consents (PC-145) states that if guardian signatures are needed on documents, Assessment and Referral can hold on to them until signatures can be obtained. Under the Five-Day Notice policy (PC-299), "Upon request for discharge by the patient and/or parent…Lincoln Prairie Behavioral Health Center staff will respond by providing him/her with the appropriate request for discharge form."

According to the Mental Health Code,

> "Any minor may be admitted to a mental health facility for inpatient treatment upon application to the facility director, if the facility director finds that the minor has a mental illness or emotional disturbance of such severity that hospitalization is necessary and that the minor is likely to benefit from inpatient treatment. …. The application may be executed by a parent or guardian or, in the absence of a parent or guardian, by a person in loco parentis." (405 ILCS 5/3-503).
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> "Whenever a parent, guardian, or person in loco parentis requests the discharge of a minor admitted under Section 3-503 or 3-504, the minor shall be discharged at the earliest appropriate time, not to exceed 5 days to the custody of such person unless within that time the minor, if he is 12 years of age or older, or the facility director objects to the discharge in which event he shall file with the court a petition for review of the admission accompanied by 2 certificates prepared pursuant to paragraph (c) of Section 3-507." (405 ILCS 5/3-508).
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> "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program." (405 ILCS 5/2-200).

The hospital can neither confirm nor deny whether the mother arrived with the patient at admission while the mother can confirm that she rode along in the ambulance as she gave consent over the phone in a 16-minute call, then sitting in the waiting room with her husband and the patient's Godmother, not being allowed to go back with the patient to complete admission papers and never receiving copies of them. Not being allowed to accompany the patient for the initial admission is consistent with the referral director's description of procedures and his statement that copies of admission documents are given to parents if they request. Meanwhile, the admission application completed on verbal consent en route, signifies that the parent/applicant was explained the rights contained on the form, including discharge rights, that she was given a copy of it and the rights of individuals when the latter form only showed being covered and given to the patient. It seems that Lincoln Prairie had the opportunity per policy to meet with the parents during admission to get signatures and review the enormity of necessary documents and rights since they were "completed" in 16 minutes, instead of 30, during what must have been a traumatic ride. A progress note from the 26th referenced the mother's demand for the patient's discharge, and although the nurse practitioner claims that the mother refused to sign a discharge request form, it is not documented that she was ever offered one. Violations are substantiated. The patient was ultimately discharged within two days of the mother's verbal request.

RECOMMENDATIONS

-Document when families arrive with patients and meet with them as appropriate to cover the necessary admission information and obtain signatures.

-Provide copies of admission applications and rights of individuals to parents/guardians as stated on the forms, not just when requested.

-Document whenever a parent requests discharge and the offering of a discharge request form.

SUGGESTIONS

-Be clearer in notations regarding the specifics of a client's concerning behavior such as assessing in the morning for conditions or behavior from the previous night.

-Patient rights posted in unit group rooms were in such small print that they were very difficult to read. The text size should be increased and posted "conspicuously in public areas" per the Code (405 ILCS 5/2-200).

The patient was given the wrong medications-

By review of the medicine administration record and interviews with nursing staff and their attorney, there is no evidence to support the complaint. It was suggested that two of the prescribed medications matched the alleged color combinations of wrong medications. The

nurse who reviewed the complaint had insufficient cause to initiate a medication error procedure. A violation is not substantiated.

RESPONSE

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