FOR IMMEDIATE RELEASE

REPORT OF FINDINGS— 20-040-9011
UNIVERSITY of CHICAGO MEDICINE/INGALLS MEMORIAL HOSPITAL
HUMAN RIGHTS AUTHORITY— South Suburban Region

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning University of Chicago Medicine/Ingalls Memorial Hospital. The complaint stated that the hospital failed to provide adequate and humane care and services as follows: 1) psychotropic medication was administered in the absence of an emergency, 2) the staff were verbally and physically abusive toward the recipient, 3) the recipient was threatened with involuntary commitment papers if she did not give consent for her records to be released to her husband, 4) the hospital did not provide the recipient with a copy of her record upon her request, 5) the hospital did not allow visitation with persons of choice, 6) the hospital did not allow phone calls from her attorney, and, 7) the hospital did not accept the recipient's written request for discharge.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4 and 110/5]).

Located in Harvey, this general medical and surgical hospital is part of the University of Chicago Medicine Group. This hospital reportedly had 54 adult beds and 24 adolescent beds on its behavioral health unit prior to March of 2020. The adolescent intake department was closed in March 2020 to provide more beds during the Covid pandemic.

METHODOLOGY

To pursue the investigation, the complaint was discussed with the hospital's legal counsels, the Assigned Psychiatrist and counsel, and a nurse. The complaint was discussed with the adult recipient, who maintains her legal rights, and sections of her record were reviewed with consent. The HRA reviewed visitation logs that were not part of the recipient's record. Relevant hospital policies were also reviewed.

Complaint #1 Medication

The first complaint stated that the recipient was administered psychotropic medication against her will and in the absence of an emergency at least three times. For example, it was

reported that the staff were yelling at the recipient for stepping out of her bedroom and then the Charge Nurse had five female staff members to hold her down and medication was administered by injection. It was reported that medication was forcefully injected without cause during her hospital's stay on other occasions.

Information from the record, interviews and program policy

The Ingalls record indicated that the recipient was involuntarily admitted to the hospital's behavioral health unit on July 4th, 2018 upon her transfer from a hospital affiliated with Ingalls. A petition and certificate were prepared by the transferring hospital on July 3rd and the 4th, 2018 at 10:50 a.m. and 9:00 a.m., respectively. According to the petition and certificate, the recipient had been transported to the transferring hospital's emergency department due to increasingly bizarre behaviors. She reportedly had been having problems with sleeping for the past ten days and had run to a school and began knocking on the doors on the 3rd. She reportedly believed that her husband was trying to deceive her by pretending to be someone else and that someone had put "something" in her beverage. The petition and the certificate asserted that the recipient needed immediate hospitalization because she was unable to provide for her basic physical needs and to guard self from serious harm. The receiving hospital's Intake Counselor affirmed that rights under this status were admonished and that a copy of the petition was provided on the admission day at 1:00 p.m. Her record contained a second certificate completed by the receiving hospital's psychiatrist on the admission day at 1:30 p.m. documenting bizarre behaviors, racing thoughts, no insight, and danger to self.

A "Psychotropic Medication Education and Consent" documented that the admitting physician's orders included Ativan, Haldol and Benadryl and that the recipient had refused to give consent for the administration of the medications. Thorazine was ordered on July 5th and Lithium and Seroquel were ordered on that next day. However, the psychotropic medication education form lacked any indication of her consent or refusal concerning the medications added to her treatment plan. There were no specific dosages of the proposed medication prescribed documented on the psychotropic medication education consent form. Her record lacked a physician's determination statement concerning whether she had the capacity to make a reasoned decision about the treatment. There were no scheduled dosages of medication administered during her hospital's stay.

A "Psychiatric Evaluation Report" dated July 5th, 2018 documented that the recipient told the clinician that she was being held against her will because her husband had been talking to her abusive family and believed that she had a problem. She reported having nightmares and that her memory had been "fuzzy" and said that her husband's brother was impersonating him and had put medication in her beverage. It was documented that she had refused medication and to sign a voluntary application and was preoccupied on finding an advocacy attorney before continuing with the psychiatric evaluation. She said that she would not sign another form without an attorney and verbally consented for the clinician to talk to her husband and to schedule a family meeting with her husband for that next week. When the recipient's husband was contacted by phone, he told the clinician that the recipient had tried to choke him two days before she was admitted to the hospital. Her record indicated that she was routinely seen by the Assigned Psychiatrist or the Resident Physician but presented with paranoia during most of her hospital's stay.

For July 5th, 2018, the progress notes and other documentation indicated that the recipient was agitated and ran out of her bedroom and pushed a staff person when her belongings were being moved to another bedroom to accommodate another patient's admission to the unit, according to the hospital's protocol. She told the staff that "I want my attorney" [and that] "I have the right to remain silent" when they tried to talk to her about the incident. She reportedly was able to comply with redirections and went back to her bedroom but came out of her bedroom again and was yelling "I don't feel safe." She was pacing up and down the hallway and started yelling louder and went back to her bedroom again upon redirections. She reported that people including the staff were threatening and trying to harm her. The need for medication was reportedly explained, while the staff stayed with the recipient in her bedroom for about 30 to 45 minutes, but the medication was refused. Ativan 2 mg and Thorazine 25 mg Intramuscularly (IM) as needed were administered because "therapeutic communication" reportedly did not work. Her record lacked a restriction of rights notice for the psychotropic medications administered on the 5th. And, there was no documentation that she was physically held during the medication incident as stated in the complaint. The Charge Nurse involved in the incident told the HRA that the recipient had continued to exhibit paranoia during the 30 to 45 minutes time frame mentioned above.

For July 6th, 2018, a nursing note documented that the recipient was inappropriately touching staff members and was not respecting boundaries and was pacing on the unit. She reportedly was redirected to go to her bedroom several times and started yelling louder that "I don't feel safe here … and you lied to me." She had started touching the staff again and refused medication by injection and kicked a staff person in her abdomen. A restraint and seclusion monitoring form documented that the recipient was physically held for two minutes because of agitation, screaming, kicking, and paranoia. A corresponding restriction of rights notice documented that Ativan 2 mg IM was administered and that the recipient had refused to accept a copy of the notice when offered. For July 7th, 2018, a psychiatric progress note recorded that the recipient believed that due to the administration of emergency medication on that previous day that she had been "medically raped" by the hospital. And, she continued to tell the staff that she wanted an attorney and refused to participate in her treatment plan.

For July 9th, 2018, a psychiatric progress note documented that the recipient had been "hypersexual" and had pulled down her pants in the community areas on the unit and asked for "double hot dog" and insisted that her request was not sexually oriented. She reportedly was very agitated and refused to talk to the clinical team and walked out of the room. A family meeting with her husband had been scheduled for that same day but was cancelled because she had refused to sign a release of information form. Later, a nursing note documented that the recipient was informed to go to her bedroom because it was time to go to sleep when she was sitting in the hallway with her journaling book. She said that "I don't feel safe here" [and that] "I don't want to be here" many times and refused medication by mouth. She reportedly became louder and redirections failed and ran into another bedroom shared by two male patients and slammed the door while she was being escorting her back to her bedroom. It was recorded that the male patients were removed from their bedroom for the recipient's safety and she kicked the nurse in her left shoulder and the bed fell on top of the nurse's right foot. Thorazine 50 mg and Benadryl 50 mg IM were administered while she was physically held down by a Behavioral Health Technician. A restraint and seclusion monitoring form documented that the recipient was physically held for one minute and was still yelling and combative upon her release from the

restraint. A restriction of rights notice documented that Thorazine and Benadryl IM were administered and that she had refused to accept a copy of the notice when offered.

For July 10th and 11th, 2018, the psychiatric progress notes documented that the recipient said that she did not remember what had happened leading up to the forced medication incident on that previous night but recalled getting an injection in her deltoid. She was described as very paranoid and said that she had been "medically raped" by the hospital and that the staff were intentionally asking her questions in the morning while she was drowsy from the medication administered on that previous night. She reportedly had been refusing to cooperate with having her vital signs monitored and said that "I almost died the other day [and was] on the floor begging and screaming for vitals." Again, she had refused to sign a Voluntary Application and a release of information form concerning her husband and referred to the meeting with the clinician as a "hearing." For July 12th, 2018, a psychiatric note documented that Lithium and Seroquel were discontinued because a petition for court-ordered medication would be prepared. The administration medication record documented that scheduled psychotropic medications were offered but refused and were not given. She was discharged from the hospital on July 16th before the petition for court-order medication was approved.

The recipient's Assigned Psychiatrist told the HRA that the recipient was very paranoid and believed that her husband was impersonating someone else when she was admitted to the hospital's behavioral health unit. The psychiatrist reported that she had tried to work with the recipient because she had refused medication and that her symptoms showed improvement and she had agreed to a family meeting. The recipient told the HRA that she had filed a complaint about the Charge Nurse and another staff person with the hospital and several community and governmental agencies. She said that she gave her written grievance to a staff member who was not named in the complaint The HRA was provided with an email dated November 2nd, 2018 from Ingalls hospital addressed to a state agency employee concerning the hospital's Charge Nurse. The email included a summary of the recipient's behaviors such as kicking a staff person leading up to the need for involuntary emergency medication on July 5th, 2018. According to the hospital administration reported, the Illinois Department of Financial Professional Regulation (IDFPR) was the agency involved in the email and that the Department did not make any further inquiries about the incident.

The hospital attorney's letter dated January 6th, 2021 stated that each patient's medical record includes orders for medications that may be used for emergency situations and that the assigned physician will determine the reasons for the medication administration. When emergency medications are administered, this will be reflected on a "Notice Regarding Restriction of Rights of an Individual" along with the medications and reasons for the medication administration. The rights notice will be made part of the patient's medical record. Regarding the July 5th incident, the hospital attorney's letter stated that the recipient's record supports that Ativan and Thorazine were properly administered under the Code. However, the HRA disagrees with this. The hospital reported that a restriction of rights notice should have been completed as required by the Code. The Authority agrees with the hospital. Additionally, the hospital attorney's letter explained that emergency medications or the use of restraints are routinely reviewed as part of the patient's care. If there is a need for repeated emergency medication, the patient's care plan is reviewed to determine if any changes or a second opinion is necessary.

The hospital's Behavioral Health Services "Psychotropic Medication Education" policy stated that consent is required for interventions such as the administration of mood-altering medication. The policy stated that medication information will be provided prior to the administration of the medication. Psychotropic medication may include anti-psychotic, anti-depressant, anti-anxiety, and mood stabilizing drugs. A patient is considered as competent if the individual has sufficient capacity to generally understand the nature of his or her condition, the proposed treatment, the risks, and any alternatives to the medication. A capacity statement will be documented by the physician or designee in the patient's record. Routine medication will not be given if the patient's lacks decisional capacity. The patient will be educated and sign the medication form prior to the administration of the medication if the patient's mental status improves. The medication form must be signed by the nurse and the psychiatrist and the patient unless it is documented that the individual lacks decisional capacity. It will be documented if the patient is willing to accept the medication but is not willing to sign the medication form in the individual's record.

According to the hospital's "Patient Rights, Denial of" policy, in the event that a patient's rights are denied for good cause by the patient's physician, according to state regulations, the notation shall include: 1) the date and time the right was denied, 2) the specific right denied, 3) good cause for denial of right, and, 4) signature of the physician. The policy stated that the patient will be informed of the denial and reason. The least restrictive means of managing the behavior, which led to the denial, will be followed. Documentation of the date a specific right was restored shall be recorded in the patient's medical record and on the rights restriction form.

CONCLUSION

According to Section 5/2-102 of the Mental Health Code,

> (a) All recipients of services shall be provided with adequate and humane care and services, 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 recipients' substitute decision maker, if any, or any other individual designated in writing by the recipient.
>
> (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 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. The physician or designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only [I] pursuant to Section 5/2-107 ….

Section 5/2-107 states that,

> An adult recipient of services…must be informed of the recipient's right to refuse 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 harm to the recipient or others and no less restrictive alternative is available …. psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

According to Section 5/2-201 of the Code, whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction.

The first complaint stated that the recipient was administered psychotropic medication in the absence of an emergency. A "Psychotropic Medication Education and Consent" documented that Ativan, Haldol and Benadryl were ordered the admission day and her refusal concerning medications. Thorazine was ordered on July 5th and Lithium and Seroquel were ordered on that next day. However, the medication education consent form lacked any indication of her consent or refusal or specific dosages of the proposed medication. And, her record lacked a physician's determination statement concerning her capacity to make a reasoned decision about the treatment when the medications were ordered. The HRA noticed that scheduled dosages of medication were not were not given during her hospital's stay.

The recipient's record indicated that involuntary emergency psychotropic medication was administered on three occasions. In the first instance, a nursing note documented that the recipient was yelling and went back to her bedroom upon redirections and exhibited paranoia. The staff reportedly had stayed with the recipient for about 30 to 45 minutes and the need for medication was explained but refused. Ativan 2 mg and Thorazine 25 mg IM were reportedly administered. Regarding the July 5th incident, the hospital attorney's letter stated that the recipient's record

supports that the medication were properly administered under the Code. However, the Authority finds that the first incident does not meet the Code's requirements for the administration of emergency medication because of the lack of documented need to prevent serious and imminent physical harm to self or others before the medications were administered on July 5th. In the second and third instances, the nursing notes documented that the recipient had kicked a staff person on July 6th and the 9th. This meets the Code's requirements for the administration of emergency medication. Her record contained restriction of rights notices except for the first instance.

RECOMMENDATIONS

1. The hospital shall follow Section 5/2-102 (a-5) of the Code and program policy that requires a physician's capacity statement to be documented in the recipient's record if services include the administration of psychotropic medication. In this case, there were no scheduled dosages of psychotropic medication administered, but the hospital must not offer or give non-emergent medication unless decisional capacity is clearly documented in the recipient's record.

2. The hospital shall follow Section 5/2-107 (a) requirements that emergency medication should only be given if there is a risk of serious and imminent physical harm documented in the recipient's record.

3. Ensure that restriction of rights notices are completed when emergency medication is administered under Section 5/2-201 of the Code and program policy. In this case, the recipient's record lacked a rights restriction notice for the emergency medication administered on July 5th, 2018.

SUGGESTIONS

1. To ensure informed consent, specify a dosage of the proposed medication on the psychotropic medication education consent form.

2. The hospital is reminded to help recipients to contact the Illinois Guardianship & Advocacy Commission if they need an attorney.

Complaint #2, 3 and 4 Possible Abuse and Record Access

The second complaint stated that the staff were abusive toward the recipient during her hospital stay many times. For example, it was reported that a Behavioral Health Technician had allegedly tried to persuade the recipient to release her medical records to her husband. And, she was restricted to her bedroom for initially refusing to comply with this. It was reported that another Behavioral Health Technician had allegedly called the recipient "stupid and [a] slut" and had accused her of having sexual relations with other patients. It was reported that the Charge Nurse had allegedly tried to close the door on the recipient's foot for requesting water from the nursing station. The third complaint stated that the recipient's psychiatrist had threatened to take her to court for involuntary mental health commitment if she did not give written consent to release her medical records to her husband. Additionally, the fourth complaint stated that the recipient was not provided with a copy of her record upon her request.

Information from the record, interviews and program policy

A progress note dated July 5th, 2018 documented that the recipient had exhibited paranoia and said that people including the staff were threatening and trying to harm her. Regarding the complaint about the alleged use of unduly persuasion inflicted on the recipient to release her medical records to her husband, the hospital administration reported that the Behavioral Health Technician named in the complaint was no longer employed at the hospital. Ingalls' response letter documented that the recipient's medical record was never released to any individual. Regarding the complaint about possible verbal abuse involving another Behavioral Health Technician, whose first name only was provided in the complaint, the hospital reported that the staff person was on medical leave during the recipient's hospital stay. Regarding the complaint about the nursing trying to close the door on the recipient's foot for requesting water from the nursing station, the Charge Nurse named in the complaint denied doing this. The nurse told the investigation team that patients usually have to ask the nursing staff for water because there are no water faucets or pitchers of water on the behavioral health unit.

For July 12th, 2018, the recipient's record contained a "Voluntary Application" documenting that she gave written consent for hospitalization under this status at 10:15 a.m. The Voluntary Application documented that the recipient was considered to be clinically suitable for voluntary admission and had the capacity to consent to admission under this status and understood her discharge rights. A copy of the Voluntary Application would be provided to any one of her choice and that rights under this status were provided. It documented that she did not want any agency or someone to be notified of her admission to the behavioral health unit. Regarding the complaint, the recipient's Assigned Psychiatrist denied having threatened the individual with involuntary commitment if she did not give written consent to release her medical records to her husband. She said that she was concerned because the recipient reportedly had choked her husband and she wanted to engage him in her treatment plan. A family member meeting was held with the recipient's consent before she was discharged from the behavioral health unit.

Additionally, the recipient's record contained two signed authorization forms to release a copy of her medical record to her attorney and, her husband and/or self on dated July 5th and 10th, 2018, respectively. A letter from the hospital's attorney explained that release of authorization forms are available on the behavioral health unit and are used to document a patient's request and authorization to share protected health information with third parties during the person's inpatient hospitalization. The same form is also used for authorizing the release of the patient's medical record and will remain on the behavioral health unit after the document is signed until the patient is discharged from the hospital. According to the attorney's letter, the hospital's practice was to put the release form with in the patient's chart and all the paper forms in the medical chart were picked up by the hospital's Health Information Management (HIM) Department after the patient was discharged from the hospital. The hospital's HIM Department will review any authorization form flagged for release of records and the request will be processed and the requested records will be released with proper authorization. The hospital's HIM Department will try to inform the patient of any deficiencies identified on the authorization form via mail and request a properly completed form. These authorization forms are usually not scanned and maintained as a part of the patient's medical record.

The hospital's "Patient Rights and Responsibilities" policy stated that patients have the right to be free from mental physical, sexual and verbal abuse and, neglect, exploitation, and corporal punishment.

According to the hospital's "Patient Protection from Abuse" policy, any hospital administrator, agent, employee, or medical staff member who has reasonable cause to believe that a patient whom he or she has direct contact has been subjected to abuse in the hospital must promptly report the abuse to the hospital administration. The hospital's Risk Management/Legal Department will promptly conduct an internal review to ensure the person's "alleged" safety upon receiving a report. All employee (newly and existing) will be trained on detection and reporting of patient's abuse and retrained at the minimal every two years.

The Ingalls' "Medical Records, Patient Inspection While Hospitalized" policy stated that the hospital is committed to facilitating patient access to his or her medical record. If the physician determines the medical record must be reviewed by the patient, a physician, nursing supervisor or designee must review the medical record along with the patient. If the patient continues to request access or copies of his or her medical record after the physician has been notified, the patient should be informed to send a written request for the record to the hospital's HIM Department post-hospital discharge.

CONCLUSION

Section 5/1-117.1 of the Code states that,

> Abuse means the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition.

Section 5/2-112 of the Code states that every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect.

Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act states that a recipient shall be entitled upon request, to inspect and copy a recipient's record or any part thereof "if the recipient is 12 years of age or older."

Section 110/5 (a) of the Act states that records and communications may be disclosed to someone other than those persons entitled listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient record pursuant to Section 4 of this Act, which includes an agent appointed under a recipient's power of attorney for health care.

The Authority does not substantiate the complaint about possible abuse. The investigation team found no supportive evidence that the recipient was verbally or physically abused as stated in the complaint. The HRA finds no violations of the Code's Section 5/2-112 or the hospital's rights statement. Additionally, the Authority cannot substantiate the complaint stating that the

hospital did not provide the recipient with a copy of her record upon her request. Although the recipient's record contained an authorization form to release her medical record to her husband and/or self and her attorney, the documents were not properly completed. Ingalls acknowledged that the hospital's Health Information Management Department should have flagged the authorization form and followed up with the recipient concerning this matter. However, the HRA finds no clear violations of Sections 110/4 and 110/5 of the Mental Health and Developmental Disabilities Confidentiality Act.

COMMENT

To correct the problem, the hospital reportedly has taken steps to ensure that all Authorization for Release of Information forms provided to its Health Information Management Department are timely reviewed and, if they are not properly completed, the patient will be notified in writing to ensure that the individual has an opportunity to properly request his or her record in a timely manner.

Complaint #5, 6 and 7 Communication and Discharge

The fifth and sixth complaint stated that recipient was not allowed visitation with her two children and phone calls from her attorney. Additionally, the seventh complaint stated that the recipient's psychiatrist had refused to accept her request for discharge form.

Information from the record, interviews and program policy

The recipient's record indicated that her children were ages 11 and 13 and that she was assigned to hospital's behavioral health unit 2b. The psychiatric progress notes documented that the recipient was a danger to self and others including her children. The investigation team reviewed visitation logs indicating that she had visitation with her husband during her hospital's stay at least seven times. The recipient told the HRA she was not allowed visitation with her children. She said that the staff could have moved to her to a floor designated for female patients where minor children are allowed visitation with patients. She reportedly was frequently "taunted" by the staff about her roommates being transferred to floors where they could have visitation with their children. The recipient wrote that "I have no guardian or substitute [decision maker] and I want my lawyer" on the admission "Emergency Treatment Information" form. Her record indicated that she told the staff that she wanted a lawyer many times.

For July 12th, 2018, a psychiatric progress note indicated that the recipient told the hospital's Patient Advocate that she wanted communication by visitation with her attorney. Her husband told the staff that the recipient had been calling and asking their tax attorney to represent her in court and that he was confused because he is an accountant. According to the psychiatric progress notes, the recipient said that the attorney mentioned above was the only attorney that she trusted to represent her in court. A nursing note documented that she had knocked on the recipient's bedroom door to tell her that the hospital's Patient Advocate was not able to talk to her attorney but had left a phone message. She reportedly became angry and had accused the nurse of barging into her bedroom.

The recipient told the investigation team that she was not allowed phone calls from her attorney and that the staff did not provide a clear answer to her request to be discharged from the unit. She said that she had told the hospital's Patient Advocate about her alleged abuse on the hospital's unit and that she immediately wanted her attorney. She reported that the hospital's Patient Advocate told her that she would "work" on her concern issues but never followed up with her. For July 12th, 2018, a clinical note documented that the recipient had talked about signing a release for discharge form because she wanted to see her children. She reportedly was offered a discharge form twice but refused. The recipient told the HRA that her psychiatrist had walked away when she tried to give her a request for discharge form and that she gave the document to the Resident Physician. The investigation team found no request for discharge forms in her record and she was discharge from the hospital on July 16th, 2018.

The hospital attorney's letter documented that staff members hired to work on the behavioral health unit must complete a department-specific orientation session conducted by experienced mental health professionals knowledgeable about Illinois law. This includes specific training on the Mental Health and Developmental Disabilities Code on the administration of psychotropic medication, the use of restraints, and the appropriate procedures to follow to ensure compliance on the behavioral health unit. According to the hospital's attorney's letter, the hospital is updating its annual competency requirements to reinforce the orientation training on the Mental Health Code.

The hospital's "Patient Rights and Responsibilities" policy stated that a patient has the right to communication with persons outside of the hospital via mail and private telephone calls. The policy stated that each patient or support person, where appropriate has the right to receive visitors of choice. They have the right to withdraw or deny such consent at any time. Visitation privileges will not be restricted, limited, or denied based on race, color, disability, etc. The suggested general visiting hours are from 9:00 a.m. to 9:00 p.m. and specific visitations hours apply to the Behavioral Health Unit and other specific areas. The hospital's Behavioral Health's Patient Handbook indicated that visitation is allowed on Tuesday and Thursdays from 5:00 p.m. to 6:00 p.m. on units 2b and 2c, Saturdays and Sundays from 10:00 a.m. to 11:00 a.m. and holidays from 4:00 p.m. to 6:00 p.m. The Patient Handbook documented that visitors must be 13 years or older for the adult units.

The hospital's Behavioral Health Services "Request for Discharge 5 or 15-day" policy stated that the hospital recognizes a patient's right to object to continued hospitalization. Its Department also recognizes that a patient might not meet the criteria for involuntary commitment but still requires hospitalization. It is the policy of the Department of Psychiatry to encourage the patient to reconsider leaving the hospital prematurely and to discuss this matter with the attending physician to forestall this decision. It is the hospital's policy to facilitate the discharge if a definite decision is made by the patient and psychiatrist to leave the hospital.

CONCLUSION

Section 5/2-103 of the Code states that,

> (c) Unimpeded, private and uncensored communication by mail, telephone and visitation may be reasonably restricted

> by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission.
>
> (d) No facility shall prevent any attorney who represents a recipient or who has been requested to do so by any relative or any family member of the recipient, from visiting the recipient during normal business hours, unless the recipient refuses to meet with the attorney.

Section 5/2-200 states that,

> 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 12 year 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 right to designate, a person or agency to receive notice under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency.

Section 5/3-403 states that,

> A voluntary recipient shall be allowed to be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after he gives any treatment staff person written notice of his desire to be discharged unless he either withdraws the notice in writing or unless within the 5 day period a petition and 2 certificates … are filed with the court.

The Authority cannot substantiate the complaint stating that recipient was not allowed visitation with her children and phone calls from her attorney. The Patient Handbook stated that visitors 13 years or older are allowed on the adult behavioral health units. The HRA found no supporting evidence that the recipient's right to communication was restricted regarding her child who reportedly meets the age requirement for visitation and her attorney. Additionally, the recipient's record lacked any indication that she had signed a request for discharge form and gave it to a staff person. The Authority finds no violations of the Code's Sections 5/2-103 and 5/3-403 and program policy. Although, the recipient did not have any visits with her 13 year old child, the HRA questions why a restriction of rights notice was not completed based on the psychiatric notes that she was a danger to her children as a preventative measure.

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

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April 14, 2021

Via First Class Mail and
E-Mail Transmission

Ms. Judith Rauls
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RE: HRA No.: 20-040-9011

Dear Ms. Boatman and Ms. Rauls:

As you are aware, our firm represents Ingalls Memorial Hospital ("Ingalls") in the above-referenced matter. We are in receipt of your letter dated March 15, 2021 from the South Suburban Human Rights Authority of the Illinois Guardianship and Advocacy Commission ("HRA") raising recommendations that Ingalls may improve the quality of patient care in its provision of emergency medication.

The letter raises recommendations for Ingalls' staff in response to the above cited investigation. Although Ingalls does not agree with the Conclusions in the letter in regards to Complaint #1, Ingalls remains dedicated to the proper care of its patients. In order to address the HRA's recommendations, Ingalls is willing to provide further training as raised in the letter. Within 90 days, Ingalls agrees to train its staff on the Behavioral Health Unit ("BHU") on (1) Section 5/2-102b(a-5) of the Code and program policy that requires a physician's capacity statement to be documented in the recipient's record if services include the administration of psychotropic medication; (2) Section 5/2-107(a) requirements that emergency medication should only be given if there is a risk of serious and imminent physical harm documented in the recipient's record; and (3) ensure that restriction of rights notices are completed when emergency medication is

administered under Section 5/2-201 of the Code and program policy. Ingalls proposes to complete the training within ninety (90) days and will provide staff training sheet with those professionals who attended.

In conclusion, Ingalls Memorial Hospital appreciates the opportunity to discuss these issues with the South Suburban HRA and to use the information learned in the process to improve the quality of patient care on the BHU. We would again like to note that Ingalls takes its obligation to all patients, including those with mental illness, very seriously. Ingalls continues to train, monitor, and review its practices and procedures in order to provide the highest level of care. While we disagree with the HRA conclusions, Ingalls will continue to put its patients first and will train staff on proper procedures for administering and documenting the administration of emergency medication accordingly.

If you would like to discuss further, please feel free to contact me.

Sincerely,

Michael T. Trucco

MTT:kp

cc: Brian Sinotte