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REPORT OF FINDINGS— 20-040-9014
SILVER OAKS BEHAVIORAL HOSPITAL
HUMAN RIGHTS AUTHORITY— South Suburban Region

INTRODUCTION

The Human Rights Authority has completed its investigation into allegations concerning Silver Oaks Behavioral Hospital. The complaint stated that a physician had threatened to take the recipient to court if he did not sign a voluntary application. Additionally, the complaint stated that psychotropic medication was administered without cause and in the absence of an emergency. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

Located in New Lenox, this 100-bed hospital provides specialized mental health and substance abuse treatment for adolescents, adults, and senior adults.

METHODOLOGY

To pursue the investigation, the hospital's Risk Manager and a nurse were interviewed, and the hospital's response letter to the complaint was reviewed. The complaint was discussed with the recipient as well and his records were reviewed with written consent. Relevant program policies were also reviewed.

Information from the record, interviews and program policies

According to the record, the recipient was involuntarily admitted to the hospital's behavioral health unit on September 22nd, 2019 around 9:44 p.m. His record contained a petition and certificate prepared by a family member and the transferring hospital on September 22nd at 3:30 p.m. and 3:45 p.m., respectively. According to the petition and certificate, the recipient had been transported to the transferring hospital's emergency department because he had physically assaulted his son and had threatened to kill him. He reportedly had exhibited psychosis and was observed to be responding to auditory and visual hallucinations. The petition and the certificate asserted that the recipient needed immediate hospitalization because he was reasonably expected to engage in physical harm to self or others. According to the Assessment and Referral Worker's progress note, the recipient had refused to [sign] all consents and a voluntary admission form and rights were provided in writing and verbally explained. The Assessment and Referral Worker documented that copies of the admission forms and the program brochures were provided.

For September 22nd, 2019, the admitting nursing note documented that the recipient had been threatening to kill his son for several weeks and had grabbed him and ripped his shirt. He reportedly was cooperative and signed a voluntary form for inpatient hospitalization. His record contained a Voluntary Application dated September 22nd, 2019 and was signed by the admitting nurse on the 23rd at 12:35 a.m. The voluntary form documented that the recipient did not want any person or agency to notified of his admission to the hospital. It stated that the recipient had the capacity to consent to voluntary admission and that all rights of admittee were explained. He was diagnosed with Schizoaffective Disorder, Hypertension and Diabetes. The admitting physician orders included Haldol and Ativan1mg Intramuscularly (IM) or orally every six and eight hours as needed. Medication for his physical medical problems were also prescribed. According to a Psychotropic Medication Consent form, the recipient gave written consent for the administration of Ativan and Haldol but lacked any indication that information about whether the medications were provided. Also, there was no physician's written statement of the recipient's decisional capacity at the time medications were ordered.

For September 23rd, 2019, the recipient's record contained an Admission Medical History and a Physical Examination Report was completed at 9:00 a.m. by an Advance Practitioner of Nursing. A Psychiatric Evaluation Report completed at 9:10 a.m. by the assigned psychiatrist documented auditory and visual hallucinations, flight of ideas, poor judgement, etc. The medication record documented that Zyprexa 2.5 mg orally or IM twice daily was ordered. A Psychotropic Medication Consent documented that information about Zyprexa was orally provided and that the recipient had refused to give consent for the medication. According to a nursing note, the recipient had requested his belt and shoes because he believed that the military forces were coming to get him out of the hospital. He reportedly had refused medication on that same day. For September 24th, a nursing note documented that the recipient was pleasant and paranoid and said that the "police think they [are] slick do [not] listen to the music." He reportedly had refused Clonidine and all psychotropic medication on that same morning. According to a psychiatric note, the recipient did not believe that he needed medication and would be encouraged to comply with medication so that he could get well. For September 25th, a nursing note documented that the recipient had refused Zyprexa and medication for his blood pressure. He told the nurse that he did not need medication and that the physician was holding him in the hospital like a prisoner.

For September 26th, 2019, a psychiatric note documented that the recipient was very agitated and had refused medication upon his admission to the hospital. He was cursing and pointing his fingers and told the clinician that he was holding him in the hospital "illegally." The psychiatrist noted that medication would be continued and titrated. For September 27th, a psychiatric note documented that the recipient was compliant with medication but was very agitated and paranoid. However, the medication records indicated that he was only compliant with medications for his physical medical problems at times. The psychiatric note also indicated that the recipient's judgment and insight were poor and that he presented with aggression and was very much out of control. Zyprexa would be increased to 5 mg twice daily and the medication would be titrated. For September 28th, a psychiatric progress note documented that the recipient had been hypersexual and reported that Lithium was discontinued in his previous treatment plan. He told the physician that he did not want to take valproic acid medication because of weight gain and that "it causes hell to your kidneys." Zyprexa 5 mg twice daily was discontinued and Zyprexa 7.5 mg orally at night was

ordered. The psychiatric note documented that the recipient had capacity to make a reasoned decision about treatment. This was the first clear capacity statement documented by the physician found in the recipient's record.

For September 29th, 2019, a nursing note documented that the recipient was compliant with medications except for Zyprexa. A psychiatric progress note indicated that the recipient had minimized his symptoms leading to his admission to the hospital. He reportedly was frustrated about being in the hospital and said that he was going to bring legal actions against certain individuals. According to the medication administration records, Zyprexa 5 mg orally in the morning was added to the recipient's medication regimen. For September 30th, a nursing note documented that the recipient said that "I'm not taking any psychiatric medicine ever." According to a psychiatric note, the recipient was actively hallucinating, calling people names, and refusing all medications. He reportedly was sexually preoccupied and was talking about sex and masturbation in the day room. He would be encouraged to comply with medication and his progress would be discussed with his son. The medication administration records indicated that Zyprexa was routinely offered and refused, and the medication was only administered on the 30th at 8:14 p.m. According to the hospital's response letter, the recipient had agreed to accept one dosage of the medication on the 30th.

For October 1st, 2019, a nursing note indicated that the recipient had refused to accept psychotropic medication but was willing to take medication for his physical medical problems. His family member reportedly had demanded that the individual should be released from the hospital. And, he was informed that only the psychiatrist could discharge him. According to a psychiatric note, the recipient's family member told the clinician that Lithium and Navane had previously been prescribed for his father and that Lithium had been discontinued because of side effects. His family member asked the clinician to order Navane for the individual and requested that Zyprexa should be discontinued. According to the medication administration records, Zyprexa was discontinued and Navane 2 mg twice daily was ordered on that same day.

For October 2nd, 2019, a nursing note indicated that the recipient was verbally abusive to the staff and other patients in the cafeteria and was escorted back to the unit and continued to be verbally aggressive toward the staff. The medication records documented that Haldol and Ativan IM as needed were administered. A psychiatric note documented extreme psychosis, agitation, non compliancy with medication and that the staff were doing their best to stabilize and prompt him to take his medication. The investigation team notes that there were no restriction notices concerning medication found in his record. According to the medication administration records, Navane was administered as ordered on that same day, and his record lacked informed consent for the medication. His record indicated that he was discharged from the hospital on that next day. A "Discharge Summary" report completed by the psychiatrist indicated that the recipient was alert and oriented times two when he was released from the behavioral health unit on the 3rd. He reportedly was free of suicidal and homicidal ideations. His cognition and memory were good, and insight and judgment were poor.

Regarding the complaint about the Code's voluntary admission process, the recipient told the HRA that the assigned psychiatrist had threatened to take him to court if he did not sign a voluntary admission form. The hospital's letter and the Director of Risk Management denied that

the recipient was threatened with involuntary mental health commitment for refusing to sign a voluntary admission form. According to the hospital's letter and the Director of Risk Management, the recipient had signed a Voluntary Application in the early morning hours on September 23rd, 2019 at 12:35 a.m., and recipient was first seen by the psychiatrist and physician on the 23rd after 9:00 a.m. The recipient's record support this. The HRA was informed that there was no need for the psychiatrist or any clinician to meet with the recipient about the Voluntary Application because he had already signed the document. The attending psychiatrist could not be interviewed because the clinician no longer has physician's privileges at the hospital according to the Director of Risk Management.

Regarding the complaint about medication, the recipient told the HRA that he was escorted from the cafeteria back to the unit by the hospital's security employees for verbally arguing with two staff members. He said that he was able to calm down and a nurse and four hospital's security employees told him that he was getting an injection. He said that he was escorted to his bedroom and medication was administered against his will. A nurse told the HRA that she was called to the cafeteria to observe the recipient on the incident day. She said that the recipient was very liable and wanted to go back to the unit before the scheduled 30 minutes lunch period had ended. She said that the recipient was informed that he would not be allowed to leave the cafeteria before the scheduled leave time. He reportedly had started cursing at the staff and patients and was escorted back to the unit by a staff person. He was not able to calm down and other patients became upset and two female patients started crying. He reportedly said, "fuck you" and other derogatory words and was escorted to his bedroom and continued to curse and tried to hit a staff person. The recipient's record does not support that he had tried to physically harm others. According to the nurse the recipient was informed that medication would be administered, and Ativan and Haldol were given. An incident report was not completed because he had accepted the medication. Additionally, the investigation team was informed that all clinical staff are trained on Crisis Prevention Intervention during orientation and annually.

The Silver Oaks Behavioral Hospital "Admission Screening Guidelines" policy stated that the hospital will comply with all regulatory standards related to the admission of patients to a psychiatric hospital. Patients may be screened by a Pre-Admission Screening Professional that includes a physician, a registered nurse, and other qualified examiners. Patients must be seen by a physician within 24 hours of admission. A physician's order for admission is needed. A person 16 years of age or older or a person younger than 16 years of age who is or has been married may request admission to the hospital. A parent, managing conservator or guardian of a person younger than 18 years of age and is not or has not been married may request the admission of the patient, except in cases where the guardian or managing conservator is an employee or agent of the state or a political subdivision of the state. A patient must have the capacity to consent for treatment as determined by the physician or the hospital must initiate emergency detention proceedings. The request for admission must be in writing and signed by the individual making the request. The patient must be informed of his or her rights as a voluntary patient prior to the person's admission to the hospital.

The hospital's rights statement includes the right to participate in all decisions involving the person's care, to be treated with respect and dignity, to give informed consent for all treatment and procedures and to be free of abuse and neglect. The hospital's "Rights Restrictions" policy stated

that a patient's rights may be restricted in accordance with a physician's order. A rights restriction should be time limited, clinically justified, and provides for increased safety and security of the patient.

The hospital's "Administration of Psychotropic Medication Against the Patient's Will in Emergency Situations" policy mirrors the Code's Section 5/2-107. Additionally, the policy stated that nursing is responsible for evaluating a patient to determine if the administration of medication is needed to prevent the individual from causing serious and imminent physical harm to self or others. The nurse shall document all pertinent information leading up to the need for the medication.

The hospital's "Unusual Incidents" policy stated that unusual incidents are generally events that are not normally expected such as a patient falling. It directs that the staff involved or who witness the incident to complete an incident report prior to the end of his or her shift. The report shall be forwarded to the hospital's Director of Performance Improvement and the Chief Nursing Officer by the end of the shift.

CONCLUSION

According to Section 5/2-102 of the 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.
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> (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.

Section 5/3-402 of the Code states that,

> No physician, qualified examiner, or clinical psychologist shall state to any person that involuntary admission may result if such person does not voluntarily admit himself to a mental health facility unless a physician, qualified examiner, or clinical psychologist who has examined the person is prepared to execute a certificate under Section 3-602 and the person is advised that if he is admitted upon certification, he will be entitled to a court hearing with counsel appointed to represent him at which the State will have to prove that he is subject to involuntary admission.

The Authority cannot substantiate the complaint stating that a physician had threatened to take the recipient to court if he did not sign a voluntary application. The recipient's record indicated that he had signed a Voluntary Application in the early morning hours on September 23rd, 2019. The psychiatrist named in the complaint who allegedly had threatened the recipient did not see him until the voluntary admission form was signed. The medical physician also did not see him before he signed the voluntary form. The Authority finds no violations of Section 5/3-402 of the Code.

The Authority substantiates the complaint stating that psychotropic medication was administered without cause and in the absence of an emergency. The medication record documented that Haldol and Ativan as needed were ordered on September 22nd, 2019 and, Zyprexa and Navane orally twice daily were added to his treatment plan on September 23rd, 2019 and October 3rd, 2019, respectively. His record contained a signed medication consent form for the administration of Haldol and Ativan but there was no indication that written medication information was provided. Another medication form documented that he had refused to give signed consent for Zyprexa and that medication information orally was provided. The medication record documented that scheduled dosages of Zyprexa were refused on September 24th, 25th, 26th, 27th, 28th, and the 29th and that the medication was not administered. One dosage of Zyprexa was administered on September 30th, 2019. The first clear physician's determination statement that the recipient had capacity to make a reasoned decision about the treatment was dated September 28th, 2019 and again on that next day. The medication record indicated that Navane was administered on October 3rd. However, there was no indication of his consent and that information about the

medication was provided. The hospital violates the Sections 5/2-102 (a) (a-5) of the Code.

The recipient's record indicated that dosages of emergency medications were given on October 2nd, 2019. A corresponding nursing note indicated that the recipient was verbally aggressive toward the staff and others in the cafeteria. He was escorted back to the unit and continued to be verbally aggressive toward the staff and as needed medications were administered. The nurse involved in the incident told the HRA that the recipient had also tried to hit a staff person leading up to the need for the medications. However, there was no documentation of any physical threat to support the need for emergency medication found in his record. Additionally, the nurse reported that an incident report was not completed because the recipient had accepted the medications, however all indications in the record and interviews suggest that he had no choice. The hospital violates Sections 5/2-107 and 5/2-201 of the Code.

RECOMMENDATIONS

1. The hospital shall follow Section 5/2-102 (a-5) of the Code 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 before the first capacity statement was recorded on September 28th, 2019, but the hospital must not offer or give non-emergent medication unless decisional capacity is clearly documented in the recipient's record.

2. Follow the hospital's rights statement that includes the right to participate in all decisions involving the person's care and to give informed consent for all treatment.

3. Review psychotropic medication consent forms with recipients when their mental status improves if they accept non-emergent medication but initially refuse to sign the form. In this case, the recipient had refused to sign the consent form for the administration of Zyprexa, but the hospital told the HRA that he had accepted the medication on September 30th, 2019. Ensure that written medication information is provided.

4. 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. In this case, Haldol and Ativan IM were administered on October 2nd, 2019 for verbal aggression according to the recipient's record. This does not meet the Code's requirements for emergent medication.

5. Complete restriction of rights notices when emergency medication is administered under Section 5/2-201. In this case, there should have been a restriction notice for the emergency medication administered on October 2nd, 2019 because the recipient had tried to hit a staff person according to the hospital's nurse.

SUGGESTIONS

1. The hospital's "Unusual Incidents" policy directs that the staff involved or who witness an incident must complete an incident report. In this case, a nurse told the HRA that the recipient had tried to hit a staff person prior to the administration of emergency medication. However, his record

lacked documentation of any attempt to physical harm others during his hospital stay. The nurse told the HRA that an incident report was not completed.

2. The recipient's record contained many entries documenting that he wanted to be discharge from the hospital before he was finally released from the unit on October 3rd, 2019. However, the HRA found no indications that he was offered a request for discharge form to complete concerning this issue. The hospital is reminded of Section 5/3-403 that states,

> 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.