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# HUMAN RIGHTS AUTHORITY- CHICAGO REGION

## REPORT 09-030-9019
## CHICAGO LAKESHORE HOSPITAL

Case summary: The HRA substantiated the complaint that Chicago Lakeshore Hospital violated the Mental Health Code when it unjustly denied a recipient's request for discharge and restrained the recipient without proper Notice. Additionally the documentation showed that if the recipient refused his numerous injections of medication he was not given Notice of his rights restrictions, and if he accepted them, he did not sign informed consent documentation, thus the HRA substantiated that the recipient received psychotropic medication in violation of the Mental Health Code.

## INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Chicago Lakeshore Hospital. Allegations state that the hospital unjustly denied a recipient's request for discharge, restrained and secluded him, and administered forced psychotropic medication. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Chicago Lakeshore Hospital is a 120-bed private psychiatric hospital located in Chicago.

To review this complaint, the HRA conducted a site visit and interviewed the Director of Intake and the Director of Risk Management. The HRA obtained the recipient's record with written consent. The recipient is an adult who maintains his legal rights.

## FINDINGS

The record indicates that the recipient was voluntarily admitted to Lakeshore Hospital on 4/06/09. Voluntary admission documents were signed by the recipient on 4/06/09 which stated in bold letters that he had the right to request discharge. The admission documents show that the recipient was alone upon arrival and did not wish for anyone to be notified of his admission. The Intake Assessment states, "Pt. was transferred from [private hospital] due to depression, S/I (suicidal ideation), A/H (audio hallucinations) and V/H (visual hallucinations). Pt. states that he has been feeling this way for a couple of days. Pt. states that the voices tell him to harm self. Pt

states that he sees his died [sic] father. Pt. denies any H/I (homicidal ideation) at this time. Pt. is currently experiencing A/H and V/H at this time. Pt. presented with a flat affect at this time." The record also contains the recipient's Psychiatric Admission Summary which states, "This is the second Lakeshore treatment and one of a number of inpatient treatments for this 37-year-old single African American male who was last in this hospital under my care in late 2007. The patient states he has been doing well up until two weeks prior to admission when he ran out of his Depakote and Ativan. He states he was taking 500 mg of Depakote and 5 mg of Ativan on a daily basis. When pressed, he admits to drinking alcohol on a daily basis and he is vague about the amounts. He states he used to smoke cocaine and marijuana but has not used any for the past six months. The patient when questioned closely has absolutely no manic-type symptoms and his presenting complaint is that he is hearing voices telling him to kill himself and he also has no depressive-type symptoms. He has never made any suicide attempts. He has never been suicidal." The recipient's provisional diagnoses are listed as Schizophrenia, Alcohol Dependence and Benzodiazepine Dependence.

The record shows that the recipient was placed in the Intensive Treatment Unit (ITU) on a detoxification protocol with a 24-hour flow sheet to record his behaviors, activity participation, vital signs, and mental and physical status. The record also contains a daily RN Assessment for the duration of the recipient's stay in the ITU. Progress Notes entered on 4/07/09 at 3:00 p.m. indicate that the recipient was involved in an altercation on the unit: "Pt. got very agitated this morning. Pt. was asking for D/C and became verbally aggressive, pt. also grabbed the oxygen tank and slammed it at the hallway mirror. Pt. also slammed the oxygen tank into a room door provoking damage on the door. Pt. was placed on QR [Quiet Room] in restraint and pt. had two PRN [as needed]. During restraints pt. was very agitated and verbally aggressive toward staff. At dr.'s order pt. continue in restraints." The next entry, made at 3:15 p.m. states, "Patient stated "I'm gonna fuck up whoever put me in here." Patient's restraints were extended. Agitated. Threatening. Continue restraint order."

Hospital representatives were interviewed about the recipient's request for discharge. They stated that recipients often say that they want to go home and they are not given the request for discharge document unless it is determined that they are genuinely ready to leave. Staff reported that they did not take the recipient's statement as a request to leave but more as a complaint or wish that he did not have to be there- they did not feel that they denied the recipient his request. Staff also stated that after the restraint episode they made every attempt to transfer the recipient but police would not take him to jail and he was not eligible for the state mental health facility. Staff reported that they spoke with the recipient and informed him that they were doing all they could to get him transferred, and at one point they asked him if he wanted to sign a request for discharge and he refused. After many attempts to transfer the recipient, a judge granted an emergency petition to transfer and he was discharged to a state mental health center.

The record contains a Restraint/Seclusion Order Sheet. It states that at 11:15 a.m. "Patient was in the hallway, grabbed the oxygen tank and slammed it on the hallway mirror. Patient is very agitated and tried to run towards his doctor with the oxygen tank in hand. Pt. slamming oxygen tank on patient door where doctor was inside." The order calls for 5-point restraints for up to 4 hours. Another Order Sheet is included which states, "Patient remains agitated and continues to make physical threats of violence towards staff. No insight into events

leading to restraints." The orders both indicate that the restraint does not pose undue mental or physical risk to the patient and the second order extends the restraint for another 4 hours. These documents also indicate that the Restriction of Rights Notices were given to the recipient, and that the facility director and program director were notified. There is a Restriction of Rights Notice included in the record for the restraint episode and for the emergency medication. The reason on the restraint sheet indicates that "Pt. still on restraints. Extension ordered from MD" which refers to the extension of the restraints- the record does not include a Notice for the initial order for restraint. The Notice for the medication states, "Pt. was in the hallway, grabbed the oxygen tank and slammed it on the hallway mirror. Pt. is very agitated and tried to run towards his doctor with oxygen tank in hand. Pt. slammed oxygen tank on pt. door where doctor was inside." The Notice indicates that the recipient received Prolixin, 10 mg intramuscularly and Ativan, 2 mg intramuscularly. The record also shows that the recipient was monitored continuously and received 15- minute checks from 11:15 a.m. until 7:00 p.m. when the restraints were removed. Both Notices indicate that the recipient received the written Notice and that he wanted no one notified of the event.

The record contains an Initial Nursing Assessment that asks recipients to identify some intervention that helps to calm them when angry or frustrated. This is part of the Aggression Assessment section of the document. This preference does not appear in the original treatment plan but is addressed by interventions developed after the restraint episode.

The recipient's original treatment plan was modified and an Individual Treatment Plan (dated 4/07/09) was developed for the recipient after the restraint episode. It states, "Since his admission to Chicago Lakeshore Hospital, Pt. has been exhibiting extremely volatile and dangerous behaviors: On 04/07/09, Pt. first provoked one of male peers by yelling, screaming, and calling names. When redirection and PRN were offered, Pt. took his shirt off, posturing and stating that he would not care about consequences for his aggression, because he had already been incarcerated before. Pt. managed to receive his PRN without incident, but he continued to be labile, agitated, and testing limits. Pt. then came to the nurse's station, and demanded his discharge. When redirected, Pt. grabbed an oxygen tank and started swinging it. As a result, Pt. broke one of the hallway mirrors, and damaged the door of the room #324. Pt. was placed in 5-point restraint." The Treatment Plan did include the recipient's stated emergency intervention preference to "seek out help", as the recipient was given a personal contact person available to him to address his concerns and needs.

Hospital representatives stated that the recipient was placed in a quiet room for his restraint episode, which is hospital practice. They stated he was placed in restraints and examined by the doctor who ordered the restraints. They reported that he was observed continuously by a nurse or a person appointed by the nurse who was trained in restraint, and the record shows 15-minute checks that monitored temperature, pulse rate, respiration, blood pressure, range of movement, circulation, liquids, meals, toilet use, skin care and circulation. The record also contains written comments on progression toward meeting the criteria to be removed from restraint.

A Discharge Summary was included in the record. In the Hospital Course section it states, "The patient was admitted to the intensive unit on precautions. He was placed on detox

status due to poor history and started on Prolixin due to his stating that he had been taking Klonopin, and was not really sure about that and the phenobarbitol was tapered over the first few days with no problems whatsoever. A few days into the hospitalization, the patient had been having a rough morning and this was on 4/07/09. I talked to the patient about behaving better in the hospital while he was here. This made him a little angry and he went back to his room. I then went into another patient's room to interview them and I heard a commotion out in the hallway and going out to see if the nurse's [sic] needed some help with the medication orders, I saw this patient standing with an oxygen tank in his hands threatening the staff with it…. Eventually, the staff was able to prevail upon the patient and he dropped the oxygen tank and was taken to restraints and sedated. Subsequent to that, the patient was agitated off and on and received many PRN's. I started him on Inderal, which I increased to 40 mg q.i.d. His blood pressure remained stable. I increased his Prolixin at bedtime and started him on Depakote for his impulsivity all of which he appeared to tolerate fairly well and was not the least bit sedated from. We consulted the hospital lawyers who stated that I should file a complaint against the recipient for the assault, which I did and the patient was discharged to the police on 4/10/09 [police denied the request and recipient remained until 4/15/09]. He did receive quite a number of PRN's that day as well as he was quite agitated."

During the recipient's hospitalization he received the following psychotropic medication through injections:

4/07/09-Prolixin 5 mg IM 8:12 am
Prolixin 10 mg IM 11:15 am
Prolixin 10 mg IM 3:15 pm
Prolixin 5 mg IM 6:50 pm
Ativan 2 mg IM 11:15 am
Zyprexa 10 mg 1:00 pm

4/08/09-Prolixin 5 mg IM 7:30am
Cogentin 2 mg IM 7:30 pm
Prolixin- 5 mg IM 1:00 pm

4/09/09- Prolixin 5mg IM 1:00 pm
Zyprexa 10 mg IM 2:30 pm
Prolixin 5 mg IM 10:45 pm

4/10/09- Prolixin 5 mg IM 10:45 am
4/13/09- Ativan 2 mg IM 1:00 p.m.

All of the intramuscular administrations were given for "agitation" and it is not clear from the record if the recipient objected, however the orders were written for oral or intramuscular administration, which implies that they were offered orally and then were given through injection. There is one Restriction of Rights Notice for the medication given during the restraint event so this indicates that the recipient objected to that administration. The recipient also received oral administrations of Phenobarbitol, Depakote, Zyprexa and Valium. There is a Psychotropic Informed Consent document in the record, however the medications listed are for

Phenobarbitol and Prolixin only. The record does not include a written decisional capacity statement for the recipient at the time his medications were proposed.

In addition to the incident involving the oxygen tank, there is one other entry in the Progress Notes to indicate a behavioral incident for the recipient. On 4/13/09 an entry states, "Pt. demanded to go home- explained that legal issues prevent that and OK in a few minutes and then lost control and code called." There is no further documentation regarding this event and it is unclear if any further action was taken. Staff were interviewed about the entry and they assumed that the recipient deescalated and the code was not needed, or that the recipient deescalated upon the show of force. The entry is not signed. The record contains daily RN Assessments and Flow Sheets for the duration of the recipient's stay through 4/15/09. There is one entry made on 4/07/09, the day of the restraint episode, and it states, "disruptive in [illegible], irritable, poor boundary." For the same day the daily RN Assessment states, "aggressive, physically violent." There are no other entries that indicate problem behavior.

## STATUTORY BASIS

The Mental Health and Developmental Disability Code states that any person 16 or older may be admitted to a mental health facility as a voluntary recipient for treatment of a mental illness "upon the filing of an application with the facility director of the facility if the facility director deems such person clinically suitable for admission as a voluntary recipient" (405 ILCS 5/3-400). Additionally, the Code states, "The written application form shall contain in large, bold-faced type a statement in simple nontechnical terms that the voluntary recipient may be discharged from the facility at the earliest appropriate time, not to exceed 5 days, excluding Saturdays, Sundays and holidays, after giving a written notice of his desire to be discharged, unless within that time, a petition and 2 certificates are filed with the court asserting that the recipient is subject to involuntary admission. Upon admission the right to be discharged shall be communicated orally to the recipient and a copy of the application form shall be given to the recipient and to any parent, guardian, relative, attorney, or friend who accompanied the recipient to the facility" (5/3-401).

The Code 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 " (5/3-403).

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment. As a means to this end, it outlines how recipients are to be informed of their proposed treatments and provides for their participation in this process to the extent possible:

"(a) 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. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient…. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. [Section 2-200 states that recipients shall be asked for

their emergency intervention preferences, which shall be noted in their treatment plans and considered for use].

(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 the 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 the physician's 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 the provisions of Section 2- 107… " (405 ILCS 5/2-102).

Should the recipient wish to exercise the right to refuse treatment, the Mental Health Code guarantees this right unless the recipient threatens serious and imminent physical harm to himself or others:

"An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. 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. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services" (405 ILCS 5/2-107).

Additionally, the Code states that whenever any rights of the recipient of services are restricted, notice must be given to the recipient, a designee, the facility director or a designated agency, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

Restraint is a therapeutic tool that the Mental Health Code carefully regulates. Although its use is to prevent physical harm, the Code outlines specific measures to ensure that it is safe and professionally applied:

"Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for the staff.

(a) Except as provided in this Section, restraint shall be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the recipient, is clinically satisfied that the use of restraint is justified to prevent the recipient from causing physical harm to himself or others. In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the recipient, that the restraint does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition. The order shall state the events leading up to the

need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours. If further restraint is required, a new order must be issued pursuant to the requirements provided in this Section….

(f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others….

(i) A recipient who is restrained may only be secluded at the same time pursuant to an explicit written authorization as provided in Section 2-109 of this Code. Whenever a recipient is restrained, a member of the facility shall remain with the recipient at all times unless the recipient has been secluded. A recipient who is restrained and secluded shall be observed by a qualified person as often as is clinically appropriate but in no event less than every 15 minutes.

(j) Whenever restraint is used, the recipient shall be advised of his right, pursuant to Sections 2-200 and 2-201 of this Code, to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint. A recipient who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice. Whenever the Guardianship and Advocacy Commission is notified that a recipient has been restrained, it shall contact that recipient to determine the circumstances of the restraint and whether further action is warranted" (405 ILCS 5/2-108).

## HOSPITAL POLICY

Chicago Lakeshore Hospital policy NS-37 Request for Release of Patient on a Voluntary Admission states that "Upon admission, the patient shall be informed orally of his rights to be discharged. The hospital shall discharge the adult patient within five working days, excluding Saturdays, Sundays and Holidays after receiving a written notice of the patient's desire to be discharged, unless within this time a petition and two certificates are filed with the court asserting that the patient is subject to involuntary admission." The hospital procedure indicates that if a patient requests to sign a 5 day notice, the staff will provide the form to him, provide a copy to his physician and the records department, and file the form in the patient's medical record.

Hospital policy NS-65 outlines the policy and procedure for the use of restraints and seclusion. This extensive procedure comports with the Mental Health Code requirements and instructs staff in all aspects of restraint.

Hospital policy NS-68 Restriction of Rights states that "There must be sufficient justification and documentation at any time the rights of a patient are restricted. Rights of patients may be restricted only within the parameters specified by the Mental Health and Developmental Disability Code of the State of Illinois." The policy states that restrictions that include the administration of medication against a patient's will must be ordered by a physician

and must include the type of restriction, clinical justification for such restriction, and the duration. The policy mandates that a Restriction of Rights form be completed by the RN and a copy is then given to the patient and to any person designated by the recipient. Copies are also forwarded to Medical Records and the Medical Director.

Hospital policy NS-43-A Administration of Medication states that "Every patient has the right to refuse any medication, including PRN's. Documentation of refusal is made in the progress notes by using the refusal stamp. If a patient refuses medication it will not be given, unless deemed necessary to prevent the patient from causing harm to himself or others; in which case the attending physician is notified. If a patient refuses a 'NOW, STAT' or one time only medication, the Physician will be contacted immediately, regardless of time and documented in the progress notes. If medication is given to a patient to prevent causing serious harm to himself or others, a restriction of rights is completed for each episode. Fully document the patient's behavior and events, which led to the decision to give the medication."

## CONCLUSION

The recipient in this case was admitted voluntarily to Chicago Lakeshore Hospital. The record indicates both in the Progress Notes and in the recipient's Individual Treatment Plan that he had requested discharge as early as 4/07, yet he was not provided with the opportunity to sign a Request for Discharge form. According to documentation, the two episodes in which the recipient became angry enough to warrant an emergency code were both precipitated by his request for discharge paperwork. Apart from the difficulties of placement for the recipient after his angry outburst, he was clearly denied his right to sign a Request for Discharge upon request as guaranteed by the Mental Health Code. Lakeshore's stated practice of providing request for discharge forms only when patients are "genuinely ready to leave" is in direct conflict with the Code's intention for that determination to come *after* a patient completes his written request.

The record shows that the recipient's restraint episode was heavily documented and the hospital is to be commended on its procedure (mandated written comments as opposed to checklist) for observations throughout the restraint event. However, there is no Restriction of Rights Notice that should have accompanied the first order for restraint. Staff indicated that this was included in the physician's order but the Notice serves statutory requirements that are not addressed in the order, and you would not send an order to anyone designated to be notified of the restriction. The second order for restraint and the order for forced medication properly included Restriction of Rights Notices.

It is impossible to determine from the record what occurred with the recipient's medication. He was given 14 injections of psychotropic medication- all for agitation- so it is doubtful that he accepted these medications voluntarily, although there was no "refusal" stamp in the record, as mandated by hospital policy. If the medications were refused there are no Restrictions of Rights Notices in the record, except for the medications given at the time of his restraint. Additionally, the recipient was monitored continually as he was on the Intensive Care Unit on a detox protocol, and the only notation of what could be construed as agitated behavior occurred only on the day of restraint, and it is described as "disruptive", "irritable", and "poor

boundary". There were no other descriptions of dangerous behaviors. If the recipient always accepted the injected medication, there were orders for Cogentin and Prolixin as oral administration and it seems reasonable that he would have chosen this route if possible. Not only does the record not explain the recipient's medication situation, but it actually obfuscates it.

Additionally, the record is missing a doctor's statement of decisional capacity and documented evidence of informed consent for Ativan, Zyprexa and Cogentin.

The HRA substantiates the complaint that Chicago Lakeshore Hospital violated the Mental Health Code when it unjustly denied a recipient's request for discharge and restrained the recipient without proper Notice. Additionally the documentation shows that if the recipient refused his numerous injections of medication he was not given Notice of his rights restrictions, and if he accepted them, he did not sign informed consent documentation, thus the HRA substantiates that the recipient received psychotropic medication in violation of the Mental Health Code.

## RECOMMENDATIONS

1. Ensure that voluntary recipients are given a Request for Discharge form upon their requests to be discharged and that they are discharged or maintained in accordance with the Mental Health Code requirements (405 ILCS 5/3-401).

2. Ensure that each order for restraint is accompanied by a Restriction of Rights Notice.

3. Ensure that absent an emergency, recipients are advised in writing of the side effects, risks, benefits and alternatives to all proposed psychotropic medications, and that the physician determines and states in writing whether the recipient has the capacity to make a reasoned decision about this medication before they are given (5/2-102 a 5). Should the recipient refuse consent, note this refusal in the record.

4. Ensure that in all instances, forced medications and other treatments are given only to prevent serious and imminent physical harm and that all staff persons understand and follow this Code requirement (405 ILCS 5/2-102, 107).

5. Instruct all staff members that Notices must be completed, issued, and entered into patient records whenever a recipient's right to refuse medication is restricted (5/2-201).

6. The recipient in this case identified an emergency intervention to "seek out help" as a means to calm himself when angry or frustrated. This was included in the Aggression Assessment of his Initial Nursing Assessment. Develop a separate document to record emergency intervention preferences and follow Code guidelines that these preferences are noted in the treatment plans and considered for use in emergency situations (5/2-200).

## SUGGESTION

1. The record of this recipient's behavior and treatment interventions does not match the description offered by staff of his violent and aggressive outbursts. The recipient was admitted into the Intensive Treatment Unit on a detoxification protocol and monitored continuously throughout his stay. During this 8 day period there was only one day in which staff documented aggressive behavior and that was the day he was placed in restraints for threatening staff with the oxygen tank. Facility staff however, described a recipient who was psychotic and violent throughout much of his stay. Remind staff to document so that the record presents an accurate clinical picture of the recipient's progress through treatment.