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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9007
CHICAGO LAKESHORE HOSPITAL

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. It was alleged that the hospital denied a recipient adequate and humane care at her court hearing and violated the Mental Health Code when they administered emergency psychotropic medication to her. 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 her legal rights.

COMPLAINT SUMMARY

The complaint alleges that Chicago Lakeshore Hospital (CLH) did not provide adequate and humane care for the recipient at her court hearings. It was said that on 9/21/09 no food or medication (the recipient is prescribed insulin to be taken with each meal) was sent to court with the recipient, even though her attorney called her social worker three days before the event and asked him to arrange for this. The recipient's psychiatrist called the facility from court and requested that the insulin be sent. The recipient left the facility at approximately 7:30 a.m. and returned at 4:00 p.m. On 9/28/09 the facility reportedly sent a tuna sandwich with the recipient to court although the recipient is allergic to fish, and the facility did not send the insulin medication. It was further alleged that on 9/29/09 the facility did not send either lunch or insulin medication with the recipient to court and the recipient was away from the facility from approximately 10:00 a.m. until 4:30 p.m.

The complaint also alleges that the recipient was administered forced psychotropic medication for no adequate reason.

FINDINGS

The record (admission Face Sheet) shows that the recipient was admitted on 9/10/09 to the Intensive Treatment Unit at CLH. Intake Assessment notes completed the same day indicate that the recipient was admitted involuntarily after being petitioned by her nursing home because she was "verbally and physically aggressive with staff." Along with an extensive list of medications, the recipient was prescribed two diabetic medications, one of which, Humalog (insulin lispro) 10 Units, was to be taken with each meal. Additionally, the recipient was prescribed Tegretol 300 mg three times daily, for which the record contains a signed consent form. Service Notes entered into the record on 9/12/09 by the recipient's attending physician state, "Pt. scheduled for court Monday to mandate aftercare. I will not accept current voluntary as patient is not capable of sequential logic and thinking and is not capable of surmising her medical need or psychological need. Pt. is clean, intense, in wheelchair for unexplained reasons, poor dentition. She is hyperactive, her affect is labile and intense, her mood is OK, her speech is rapid, dramatic, her boundaries poor, she is distractible and thinking is extremely tangential. Her thoughts are filled with extremely delusional, grandiose, and paranoid ideas- she is a millionaire, mother of 15 children, made up of every race, a lawyer, a nurse, taking over the [previous placement]. She has no insight, no judgment, unable to engage in a discussion about her care, narcissistic, borderline and manic elements with profound underlying depression. I will go to court Monday [9/14/09] to follow up on community and judge's efforts to mandate outpatient care."

The record (progress notes) shows that on 9/14/09 the recipient left the facility for court at 8:20 a.m. and that "pt. received morning meds, including scheduled insulin, Pt. received breakfast tray, fasting accucheck was 142. Pt. in good spirits when she left unit." The next entry made at 1:00 p.m. describes the court event: " 'I know I was acting terrible on the way here, but that's because I was really scared.' Pt. stated above to this writer while at court. While in transit to court in a.m. pt. was yelling at the driver to turn on the music and air conditioning, threatening to sue them and pretended to have a heart attack. Pt.'s next court date is for this coming Friday [9/18/09]. Behavior in ambulance on the way back was much improved."

There is no entry in the record for a court appearance on 9/18/09. The next court date recorded in the progress notes is 9/21/09. The recipient's attending physician writes the only comments regarding this event: "I accompanied pt. to court today and discussed options for tx [treatment]: appropriate levels of care for pt. Pt. pretended to be deaf in front of judge. Will meet with pt. tomorrow to review current tx [treatment] plan and get her objectives for our tx plan over next 7 days until returning to court next week."

Hospital staff were interviewed by the HRA regarding court visits and the need for food and medication. The Intake Director stated that there are weekly treatment team meetings and at this time staff discuss those recipients who will be attending court in the upcoming week. He stated that after the recipient's first court appearance he told the Director of Clinical Services to make sure there was lunch and medication sent with the recipient, however he did not ever get confirmation that this had actually been done. For the court date on 9/21/09 the Director stated that staff had been told they would be the first case heard, and when the doctor realized they were not first and it would take a lot longer than anticipated, he then called for the recipient's insulin. Staff reported that generally if staff know that recipients will be at court all day, for

instance if they are going to trial, the facility will send a lunch. However, if the recipient requests to go to court for a continuance, then they are usually back to the facility before lunch.

The record (progress notes) for 9/28/09 state that the recipient went to court and was there from 8:00 a.m. until 2:40 p.m. The notes indicate that the recipient had lunch "at the court house" and there is no mention of her medication. This entry also indicates that the recipient will again be going to court the following morning and states under the Plan section of the notes, "To take Pt. tomorrow morning to court. Pt. should bring breakfast and lunch and pt.'s chart. Please let doctor … know he should be present tomorrow at court."

Hospital staff were interviewed regarding this entry since this is the court date that involved the tuna sandwich. Staff stated that the recipient often said she was allergic to many substances, and she was noted to be a poor reporter and historian. They were not aware of a fish allergy. The recipient's Medical History and Physical Exam indicates allergies to Doxycycline, Thorazine and Haldol. The Intake Medical Screen does not indicate any allergies, however on the top of the recipient's 10 pages of PRN (as needed) Medication Administration Record, as well as the bottom of the regular Medication Administration Record, an allergy to seafood is noted. Staff did not know how this information was obtained.

There is an entry in the progress notes on 9/29/09 at 6:00 p.m. which states, "return to unit from court with unit staff and 2 EMTs in ambulance on cart. Body search done with no contraband found. BS (blood sugar) upon return was 117, regular Insulin dose given and dinner tray given." These are the only comments regarding this court appearance.

The PRN Medication administration record indicates that the recipient received 6 injections of psychotropic medication while she was a recipient at CLH from 9/10/09 until 10/19/09:

1. 9/12/09 Thorazine 100mg for "agitated". There is no entry in the progress notes to describe this event and no Restriction of Rights document.
2. 9/18/09 Thorazine 100 mg for "agitated". Progress notes entry: "Today pt. was interviewed in QR (quiet room) after becoming assaultive. She was lying on the ground. Her mentation was slowed secondary to Thorazine given for acute agitation moving around by rolling on the floor as patient cannot have wheelchair in quiet room. Yelling out to/at staff. Thinking seemed more sequential than previous interviews- likely secondary to benefit of antipsychotic but pt. refuses antipsychotics saying erroneously that she is allergic. Today her threat was that she was going to get a jury trial and sue for rights violations. Emotionally labile, intense, tearful, circumstantial speech." There is no Restriction of Rights document.
3. 9/20/09 Thorazine 100 mg for "agitated". There is no entry in the progress notes to describe this event and no Restriction of Rights document.
4. 9/21/09 Thorazine 100 mg for "agitation". There is no entry in the progress notes for this event and no Restriction of Rights document.
5. 10/05/09 Ativan 1 mg for "agitated". There is no entry in the progress notes to describe this event and no Restriction of Rights document.
6. 10/13/09 Ativan 2 mg for "anxiety". There is no entry in the progress notes for this date.

There is one Restriction of Rights document in the record, dated 9/26/09. The restriction listed is “physical escort to Quiet Room.” The reason described is, “Patient displaying impaired judgement; oppositional and defiant. Purposely agitated the milieu. Provocative behavior endangering to self and others. Physically placed pt. in wheelchair to remove to open Q.R.” The progress notes for this event are described under the heading of “Milieu Disruptive Bx (behavior)”. The notes state, “Pt. provoking roommate and disturbing …(illegible) milieu with loud oppositional and defiant arguing. Refused redirection to stop loud, disruptive singing during quiet time. Pt. provided with concrete redirection, patient advised how behavior destabilized unit and could constitute self endangering bx [behavior]. Oppositional, defiant, disruptive, obstructive of tx [treatment] of other patients. Remove from milieu to open QR for pt. safety and well being of other patients.” The record, including the treatment plan, contains no Preferences for Emergency Treatment documentation.

Staff were interviewed by the HRA regarding the administration of injected psychotropic medication. They stated that not all injections are necessarily forced medication and that recipients may even request an injection as it alleviates symptoms more rapidly. The HRA noted that a stamped statement is included in the progress notes for prescribed medications or lab work that are refused (the recipient refused medication or lab work on 9/17/09, 9/20/09, 9/24/09, 9/25/09, 9/26/09, 9/27/09, 9/29/09, 10/01/09, 10/05/09, 10/08/09, 10/10/09, 10/11/09, and 10/14/09), so they wondered why staff would not note when injections are accepted. Hospital staff were amenable to a stamp to indicate this preference in the record. Staff were also questioned about the use of the quiet room. They stated that this was used just to remove the recipient from the milieu but that the door remained open and the recipient was able to leave at will. The staff do not consider this use of the quiet room as a seclusion.

The recipient had her final court hearing on 10/19/09 when she was discharged to a nursing home.

STATUTORY BASIS

The Mental Health Code states, "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." (405 ILCS 5/2-112).

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).

HOSPITALPOLICY

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 clinical record shows that of the recipient’s four visits to court she was only provided lunch by the hospital in one instance and even for that day she was not given her medication which was prescribed for each meal. For the court date on 9/21/09 the attorney reminded the

social worker to have lunch and medication sent with the recipient and still the recipient's physician had to call the facility and request her medication. Although hospital staff discussed the fact that the recipient would be away from the facility, no one took the responsibility to ensure that she was given her food and medication while she was away. That could be neglect under the Code, although we have no proof of whether it caused injury or deterioration in the recipient's physical or mental condition. What we do know is that this is not adequate care and services pursuant to the recipient's individual services plan.

It is impossible to tell from the clinical record if the injected psychotropic medication the recipient received was forced; hospital staff allege that the recipient may have agreed to the medication. In that case, there is no evidence of having her informed consent for the Thorazine or Ativan that were administered. Consent was only provided for Tegretol per the record, which, based on the physician's statement that the recipient was incapable of sequential logic and surmising medical and psychological need, perhaps should never have been ordered under the Code's decisional capacity rule for medications. It is clear from the record that the recipient often refused her regularly scheduled medication, which is indicated by a stamp used in the file to indicate such, so it is difficult to assume that she would have accepted injected emergency medication. It is likewise impossible to discern the reason for the injections, since the progress notes do not even mention an incident requiring injected medication, as required by hospital policy and procedure. The PRN Medication Administration Record offers only the words "agitated" and "anxiety" which are both too vague to be useful in justifying injections since they do not indicate threat of serious and imminent physical harm to the recipient or others when no less restrictive alternative was available. Taking all these circumstances into consideration, the record suggests that the recipient did indeed receive forced psychotropic medication and that the hospital did not follow the Mental Health Code in lacking documentation to justify overriding the recipient's right to refuse medication and lacking Notices of Rights Restrictions.

The HRA substantiates the complaint that the hospital denied the recipient adequate and humane care at her court hearing and violated her rights under the Mental Health Code when they administered emergency psychotropic medication to her.

RECOMMENDATIONS

1. Develop and implement a procedure for securing food and drink or a means to obtain food and drink for recipients attending court hearings and other appointments, in the event that they are detained beyond their normal meal time. The same procedure applies to scheduled medication.

2. Ensure that in all instances, forced medications and other treatments are given only to prevent serious and imminent physical harm and that this justification is recorded in the clinical record. (405 ILCS 5/2-102, 107). Although this recipient's record describes a very difficult patient, it never describes behaviors which rise to the level of potential serious and imminent physical harm.

3. 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).

SUGGESTIONS

1. Include in patients' treatment plans their preferences for emergency treatment and ensure that they are considered for use should the need arise.

2. Always secure informed consent based on written decisional capacity determinations whenever a psychotropic medication is ordered (405 ILCS 5/2-102 a-5).