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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9011
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 (Lakeshore). It was alleged that the hospital admitted, restrained, and administered psychotropic medication to a recipient in violation of the Mental Health Code. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Lakeshore 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 Risk Management, the social worker and the attending physician. The HRA obtained the recipient's record with the guardian's written consent.

COMPLAINT SUMMARY

The complaint alleges that the guardian was told upon her ward's admission that she would only be hospitalized for 2-3 days for assessment. The guardian signed a voluntary application on the assumption that her daughter would be discharged within 5 days after her request for her discharge. Although the guardian requested discharge four times (10/19, 20, 21, and 22) and even told staff that she would seek help elsewhere she was told, "It isn't that simple." On 10/19/09 the guardian spoke with hospital staff and told them that she had signed her daughter in and she felt she could sign her out. On 10/20/09 the guardian spoke with the medical director and again expressed that she wanted her daughter discharged and was told, "There isn't a judge around who would side with you." The complaint also alleges that the guardian sent an e-mail to the Director of Performance Improvement on 10/20/09 and 10/22/09 and stated that she wanted her daughter discharged. The recipient was discharged on 10/27/09.

On 10/18/09 the complaint alleges that the guardian was told by staff that her ward had been rude to staff and that "most times' when recipients escalate they are given medication to calm them down. The guardian allegedly told staff at this time that she did not want her ward to be given any medication without the guardian's consent. The ward reported to her guardian at this time that she had been given two injections and that 7 people had held her down to administer it. Allegedly the recipient was administered forced psychotropic medication and placed in seclusion and restraint without her guardian's notification. The complaint alleges that the guardian did not receive notice of forced psychotropic medication and restraint until days after these events. Even though the complaint alleges that the guardian visited her ward every day that she could visit, called her ward every day, and gave every number where she could be reached, the staff claimed that the guardian could not be reached.

Additionally, the complaint alleges that on 10/22/10 the guardian was called and told that her ward would be started on medication and the guardian refused to give consent. She told the physician at this time that she disagreed with the diagnosis and wanted her ward discharged. When the guardian visited her ward on 10/23/09 she felt that her daughter seemed "out of it". The ward later called her guardian around midnight to tell her she had been given a shot to calm her down and could not function when her guardian had been there. Staff had not mentioned this to the guardian while she was at the facility.

FINDINGS

The record (Admission Face Sheet) shows that the 17 year old recipient was taken to Lakeshore on 10/16/09 after being transferred from a hospital emergency room where her guardian had taken her to be assessed for aggressive behavior. The Application by an Adult for the Admission of a Minor is included in the record and indicates that the recipient was admitted at the request of her guardian and that the guardian and the recipient were explained the Rights of Recipients and given a written copy of the Rights of Recipients document (signed by both the recipient and guardian). The Examination of a Minor for Admission or Continued Hospitalization document indicates that the recipient has a mental illness or emotional disturbance and that she is likely to benefit from inpatient treatment. This opinion is supported by the statement, "Impulsive and aggressive behaviors. Hx [history] of worsening oppositional/defiant bx [behavior]". The certification that the recipient was informed of the purpose of the examination and that she did not have to speak with the examiner or that the information she gave could be used in a mental health court hearing is signed by hospital staff. The initial diagnosis is listed as Oppositional Defiant Disorder.

The recipient's Intake assessment states, "17 yr old AA female presenting as a transfer from…emergency room. Per Pt.'s mother, she brought her daughter over to … b/c she is concerned about her daughter's on-going dangerous bx. The catalyst for coming in for treatment is that the Pt. got arrested yesterday at school after attacking a police officer when the officer asked her for her school ID. The Pt. states that she didn't have her school ID, got into an argument w/the officer, he then grabbed her arm and she deflected him from trying to grab a hold of her. The Pt. states she didn't attack the officer. The Pt. was arrested at school. Upon assessment with the Pt., she is guarded, often smiling at the questions staff asked of her and states she is not really sure why she was brought to the hospital in the first place. A sheet of

paper with the words 'Murda Mother' was included w/her paperwork from … When asked about this the Pt. smiled and then later stated that it's the name of a rapper. The Pt.'s mother states that for the last two years her daughter has been increasingly oppositional, aggressive at times and defiant. She recently got upset and broke a door mirror at home. Her mother reports that she gets easily upset, will yell and periodically throw or break things. She in the past has run away from home, will refuse to go to school and will sleep all day in bed. The Pt. gives no precipitant as to why she gets upset or what bothers her. Her mother believes that something may have happened to her but that her daughter is quiet usually and keeps her feelings to herself…."

The record contains a form for "Psychotropic Medication Informed Consent" which indicates that the guardian consented to the medications Prozac and Risperdal on 10/22/09. There is no identified Preferences for Emergency Treatment form in the record.

The recipient's Initial Psychiatric Treatment Plan includes precautions for suicide, assault and elopement, collateral information gathering, consideration for mood stabilizer, group and milieu therapy, and discharge planning. The recipient's Multidisciplinary Treatment Plan listed three long term goals: "To verbalize angry feelings in a socially acceptable manner, to gain insight into defiant behaviors and make necessary behavior changes, and be able to function within the program without defiant behaviors". The recipient's short term goals are listed as: "Patient will not have more than 2 occurrences of non-compliance with unit rules in 3 consecutive days, and Patient will identify at least 2 positive and negative consequences of his/her behavior." There is no indication from the record that the recipient achieved or did not achieve her stated goals. The Treatment Plan indicates that the recipient's family is involved in her treatment however on the treatment team list of signatures there is no space for the guardian and there is no indication that the plan was shared with or approved by the guardian. There is no identified emergency treatment preferences form in the plan or clinical record.

On 10/18/09 progress notes indicate that the recipient had a family social service session at 3:45 p.m. At the end of the entry the writer notes that the recipient indicated that a nurse had wanted to give her Benadryl "for irritable behaviors", while the recipient repeatedly stated that she had a headache. This note indicates that "Pt.'s doctor can reach mother at 2 p.m.- phone number indicated in front of chart."

On 10/18/09 nursing notes indicate that the recipient had been placed in seclusion and was given medication for the following reason: "…walked into dining room with pts' pops. This pt. grabbed a pop off the tray and began drinking a peer's drink. She was redirected by several staff. Pt. refused to comply with directives. Affect was incongruent with observed aggression. Pt. exhibited laughter through incident and was verbally aggressive towards staff. Staff needed to forcibly take away pop and began escorting pt. out of the room as peers became agitated by her bx. Pt. began to grab for other food and began swearing and struggling with the single staff escort. Pt. was escorted in a 2 man backward escort to QR [Quiet Room]…." The Restriction of Rights notice accompanying the seclusion indicates, "Pt. was aggressive in day room by displaying poor boundaries, escorted to QR, refused oral meds, and swearing and threatening staff. Pt. lunged at staff and kicked door." There is also a Restriction of Rights notice for the medication and it states that the recipient was given Thorazine, 25 mg and Benadryl, 25 mg IM (intramuscularly). The record contains a restraint/seclusion record and indicates that the

recipient remained in seclusion for 1 hour. The Restriction of Rights notice shows that the guardian was mailed a copy of the notice of the administration of medication.

On 10/20/09 progress notes indicate that the recipient was placed in restraints: "Pt. had an aggressive, defiant episode. Staff instructed her to return to her room. She disobeyed orders and returned to day room. When instructed to return to her room again, Pt. threw milk carton at staff member and was restrained 1 hour in QR. Was given Benadryl, 25 mg and Thorazine, 25 mg IM." The Restrictions of Rights notice for the restraint states: "Adolescent acting somewhat bizarre, escalating behavior, screaming, threw objects at staff (milk carton)". The Restriction of Rights notice for the medication states, "Pt. agitated, threw milk carton at staff, yelling, not able to follow direction. Escorted to QR. To protect others from harm." The record contains a restraint/seclusion record and indicates that the recipient remained in restraints for 1 hour. The Restriction of Rights notice shows that the guardian was mailed a copy of the notice of restraint and medication.

The same day as the above restraint the record contains an attending progress note. It states, "17 yr. old AAF pt. seen this am laying in bed, tired, slow to answer qs, denied anything happened to her last night even though the nurse note indicated that she was disruptive in group, throwing a toy at peers and other 'bizarre bx' and was placed in QR. Her mother called and demanded that pt be discharged in one hour. Mom said that she was very upset for nothing had been done for the pt and that she saw in person that pt was mistreated last night. She couldn't tolerate about it…."

On 10/21/09 a note is made by the recipient's physician that states, "Mother called on 2 times/messages left. Recommending Risperdal and Prozac. Pt.'s behavior continues to be antisocial, oppositional and confused. If no progress on med consent, may need to activate child protection."

The guardian provided to the HRA a copy of the e-mail sent to the Director of Performance Improvement on 10/20/09 and 10/22/09 both of which object to the admission of her ward and request that the ward be discharged immediately.

On 10/22/09 the attending physician wrote a progress note stating, "…The writer talked to pt.'s mother yest afternoon and this am, who seemed to have difficulty accepting her daughter's mental diagnosis, denying pt has had violent behavior, thinking risperdal is too strong medication for her daughter's 'minor condition'. After explanations offered again about the meds and pt's mental condition/diagnosis, she wanted another day to think of giving consent. No new physical restraint." At the bottom of this page is the physician's note stating, "Later in evening I spoke to mother and secured consent for Prozac and Risperdal. Pt. was bizarre …weepy, suspicious. As above, consent secured, meds started."

The same day as above the recipient and her guardian had a family session by phone. The progress notes state, "SW [social worker] called mother for family session by phone. Dr. spoke with mother regarding possible medication for pt. Mother asked Dr. multiple questions, and Dr. explained that he feels it will benefit her presenting needs. Mother agreed to consent to medication, but expressed concern regarding pt.'s anticipated length of stay. Dr. and SW

reiterated that pt. needs to show some level of improvement for that to happen including attending group, being cooperative in the milieu…."

On 10/23/09 the attending wrote a progress note stating: "…Pt. seen this morning, said that she didn't want to talk to anybody. She reportedly has been difficult to follow instructions, alternatively weeping and smiling, refused to take her new meds saying that her mom did not want her on the meds (mom gave her informed consent to Dr. on phone yesterday pm family session; pt. told her mom she was so scared here; thought her food was contaminated; meds could poison her; trashed most of her breakfast am. She was given prn (as needed) meds later to calm her down. She was placed on LOS [Line of Sight] for her safety. The writer called her mother to update her daughter's condition this am who still sounded angrily saying how my daughter could trust you guys after you have treated her so badly but couldn't elaborate…." The recipient's physician later the same day entered a note stating, "Discussed with mother. Mother is requesting transfer to another hospital because she believes there is too great a communication and trust divide with her treatment team. Pt. cannot be discharged so she will be transferred."

On 10/23/09 the record indicates that the recipient was wandering into other patients' rooms and attempted to go onto the child side of the unit. The record contains a Restriction of Rights notice for medication. The stated reason is "Unable to follow direction, walking into other pts' rooms, threatening staff." The notice indicates that the recipient was administered 25 mg Benadryl and 25 mg Thorazine IM. The notice indicates that the guardian was mailed a copy of the notice.

The record contains a Restriction of Rights notice issued on 10/24/09 for medication given for "Pt. was agitated". The recipient was administered Benadryl, 25 mg PO (orally) and the notice indicates that the writer attempted to call the guardian however the phone number was not correct. This incident is not mentioned in the progress notes.

On 10/27/09 the attending entered a progress note indicating that the guardian had arrived at the hospital and was given discharge information. The recipient was discharged to her mother on 10/27/09.

Hospital staff response

Hospital representatives were interviewed about the inclusion of the guardian in the recipient's care and decision making. They stated that the guardian was active in the recipient's care and took part in family sessions as well phone conversations regarding her care.

Staff reported that restraint and forced psychotropic medication are used only for therapeutic purposes to prevent the recipient from harming herself or others. They stated that staff are trained in the use of restraints and whatever staff are on duty and needed to secure the safety of the recipient and others would be utilized. Although the Restriction of Rights Notices were mailed to the guardian, staff felt that they were sent in a timely manner.

Hospital staff were interviewed regarding the recipient's medication protocol. They stated that the recipient was admitted, evaluated and treated for aggressive, threatening behavior and

that she remained aggressive and threatening throughout her hospital stay. They described incidents of throwing objects at staff, kicking doors, swearing at staff and struggling with staff escorts. The medication protocol that was ordered by her physician was meant to address this issue, however the staff felt that the recipient's guardian did not realize the seriousness of her ward's diagnosis and was reluctant to agree to a medication regime. The recipient's physician was asked about the statement in the record that "If no progress on med consent, may need to activate child protection." He stated that this is not the standard response to guardians who will not consent to medication and that this decision is based on the severity of the patient's symptoms, which in this case indicated a need for medication since she was not progressing with her treatment plan. He stated that the guardian was not apprised of this option and as a rule the guardian would not be told of this action. He also stated that he has never activated child protection for the purpose of obtaining consent for medication.

Hospital representatives were interviewed about the guardian's request for her ward's discharge. They stated that based on the severity of her symptoms she was not appropriate for discharge until she had made progress on her treatment plan. Staff stated that they did not offer the recipient or her guardian a request for discharge form. All requests were written by the guardian and sent to the hospital staff or verbally spoken to the staff.

STATUTORY BASIS

The Mental Health Code states that any minor may be admitted to a mental health facility for inpatient treatment upon application of a parent or guardian and the statement of a qualified examiner that the minor meets the standard for admission (405 ILCS 5/3-503). Additionally, whenever a parent or guardian requests the discharge of a minor under this provision, the minor must be discharged at the earliest appropriate time, not to exceed 5 days, unless within that time the minor, if she is 12 years of age or older, or the facility director, objects to the discharge and in that case the director must file a petition and two certificates with the court to review the admission (5/3-508).

The Mental Health and Developmental Disabilities Code provides for the inclusion of the guardian in all aspects of treatment:

"A recipient of services shall be provided with adequate and humane care 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…."(405 ILCS 5/2-102).

If treatment includes the administration of psychotropic medication, then the guardian must be advised in writing of the side effects, risks and benefits of the treatment:

"If the services include the administration of…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 that is 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." (405 ILCS 5/2-102 a-5).

The Mental Health Code also allows the guardian to refuse treatment for the recipient:

"An adult recipient of services, 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. 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. 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." (405 ILCS 5/2-107 a). Additionally, the Code states that upon commencement of services or as soon thereafter as the recipient's condition permits, the guardian shall be informed orally and in writing of the rights that are guaranteed by the Code which are relevant to the recipient's services plan, and the recipient's preferences for emergency treatment are to be communicated to the guardian (5/2-200)".

And, whenever a guaranteed right of the recipient is restricted, the recipient and his/her guardian must be given prompt notice of the restriction and the reason therefore. (405 ILCS 5/2-201 a). The Secretary of Human Services and the facility director of each service provider must adopt written policies and procedures to implement the rights guaranteed by the Mental Health Code (5/2-202).

The Mental Health Code outlines specific directives for the use of restraint. Restraints may only be used as a therapeutic measure to prevent physical harm, based on a physician's written order that states the events leading up to the need for restraints, the purposes for them, the length of time they are to be used and the clinical justification for that period of time. The person being restrained must be observed no less than every fifteen minutes and a record of the observations must be maintained. Whenever a recipient is restrained, a staff person must remain with her at all times unless she is secluded, and she is to be afforded her right to have anyone of her choosing notified (405 ILCS 5/2-108).

HOSPITALPOLICY

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-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. The policy does not include guardian notification.

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. The policy is not specific to minors being restrained.

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."

Hospital representatives stated that there are no policies which directly outline the rights of guardians. The policies provided were general policies and not specific to minors.

CONCLUSION

The recipient's guardian in this case applied for the admission of her ward to inpatient treatment based on the assumption that when she requested her daughter's discharge her daughter would be discharged at the earliest appropriate time not to exceed 5 days. The guardian has stated that her first request for discharge was filed on 10/19/10 and the record indicates the first request on the following day. Although hospital staff explained that the recipient had not made progress toward her treatment goals, this is not documented in the treatment plan, and nevertheless the recipient should have been discharged unless the facility was prepared to file a petition and two certificates with the court, which they did not.

The record indicates that the recipient had her rights restricted on 10/18/09 for seclusion and forced psychotropic medication and 10/20/09 for restraint and forced psychotropic medication. The corresponding documentation supports the restraint episodes and complies with all requirements of the Code, except for a Preferences for Emergency Treatment form which is not part of the record and is not part of the treatment plan. The Restriction of Rights Notices indicate that they were mailed to the guardian. The guardian states that she did not receive Notice until much later than the events, and that she visited or called her daughter each day that

it was allowed but still was not informed of the incidents until much later. The record is unclear and does not indicate how long it took to notify the guardian, however since the record does show numerous times that the guardian was notified by phone and spoken to in person, it seems strange that she was not given notice in person or by phone. The hospital policy does not include the guardian in the list of persons to be given notification of rights restrictions, and there is no hospital policy which directly states the rights of guardians.

The record shows the recipient had her rights restricted on 10/23/10 for medication and on 10/24/10 for medication. The corresponding documentation is less supportive of these interventions. The Restriction of Rights Notice from 10/20 states, "Unable to follow direction, walking into other pt's rooms, threatening staff." It is not clear from the record what the threatening behaviors are however the description of them does not suggest the threat of serious and imminent physical harm. The Restriction of Rights Notice from 10/24 states "Pt. was agitated", which is so generic it does not describe any behavior, and the incident was not recorded in the progress notes which suggests a less serious event than an imminent threat of physical harm. The note on this Notice indicates that staff attempted to call the guardian but the number was incorrect, even though the guardian had been called numerous times by this date.

Although the record shows that the guardian and recipient were given information regarding the risks, benefits, and side effects of prescribed medication, the record shows that there was considerable pressure on the guardian to consent to this treatment after she initially refused. The HRA cautions that the use of child protection services as a means to obtain consent is coercive and should not be pursued. Additionally, the record is missing a statement of decisional capacity which is a requirement under the Mental Health Code.

The HRA finds that the guardian admitted the recipient on the assumption that she could be discharged within 5 days of requesting discharge, and because this contract was not honored by the hospital the HRA substantiates that the admission process was in violation of the Mental Health Code. The restraint issue shows that Restrictions of Rights Notices were not promptly issued to the guardian, and the record contains no Preferences for Emergency Treatment, thus the HRA substantiates that the recipient was restrained in violation of the Code. Finally, the record shows that the hospital failed to show serious and imminent threat of physical harm when it administered forced psychotropic medication to the recipient and the record contained no physician statement of decisional capacity, thus the HRA substantiates that the recipient was administered psychotropic medication in violation of the Mental Health Code.

RECOMMENDATIONS

1. Develop policy and train staff that when a minor is admitted on the application of a parent or guardian that the recipient must be discharged at the earliest appropriate time (not to exceed 5 days) after the guardian requests it. If there is an objection on the part of the minor or the facility director, then a petition and 2 certificates must be filed with the court (405 ILCS 5/3-508).

2. Ensure that the recipient and the recipient's guardian are given the opportunity to refuse generally accepted mental health services including but not limited to medication. If such

services are refused, ensure that they are not given unless they are necessary to prevent the recipient from causing serious and imminent physical harm to themselves or others and no less restrictive alternative is available." (405 ILCS 5/2-107 a).

4. Develop policy and instruct staff that the guardian must be given prompt notice whenever a guaranteed right of the ward is restricted (405 ILCS 5/2-201 a). This includes whenever the recipient is restrained, secluded, or receives forced emergency medication.

5. Develop policy to address the recipient's preferences for emergency treatment and communicate these preferences to the guardian (405 ILCS 5/2-200).

6. Include physicians' written statements of decisional capacity whenever services include the administration of psychotropic medication (405 ILCS 5/2-102 a-5).

SUGGESTION

1. Develop policy which specifically addresses guardians' rights and include the guardian in treatment plan development. Add a signature line in the treatment team signatures for the guardian.