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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9013
LORETTO 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 Loretto Hospital. It was alleged that the recipient was not evaluated in the 8 days in which she was a recipient there, that she never saw a physician, was not given her rights or allowed to speak with an advocate or her own physician, and told that if she did not take her medication she would be sent to a state mental health facility. If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), and hospital policies.

Loretto is a private medical facility located in Chicago. The hospital emergency department assesses approximately 1200 patients per year for mental health referral to the 72-bed Loretto behavioral health unit, to a state mental health center or to another mental health facility.

To review these complaints, the HRA conducted a site visit and interviewed the Associate Vice President of Behavioral Health and Addictions, the Assistant Nurse Manager of Behavioral Health, the Vice President of Performance Improvement and Risk Management, the Director of Case Management, and two RN's from the Behavioral Health Unit. Relevant program policies were reviewed as were the recipient's records upon written consent. The recipient is an adult who maintains her legal rights.

## COMPLAINT SUMMARY

The complaint states that the recipient had been taken to Loretto Hospital Emergency Department (ED) after having been petitioned for involuntary treatment by the social worker at her apartment. At Loretto, the complaint alleges that the recipient was not evaluated in the 8 days in which she was a patient there, was not given her rights or allowed to speak with an advocate or her own physician, and told that if she did not take her medication she would be sent to a state mental health facility.

## FINDINGS

The Loretto Hospital record indicates that on 10/05/09 at 3:03 p.m. the recipient arrived in the ED on a petition for involuntary admission from the staff at the housing complex where she was living. The statement of the signs and symptoms of mental illness are: "Client presents a psychosis. Client is hallucinating and delusional. Client poses a risk to herself and others. Client is combative and uncooperative." The ED record indicates that the recipient was uncooperative with the medical examination and "talking loudly, flight of ideas, and inappropriate." The chief complaint is listed as "psychiatric" and the question of whether anything has made the symptoms better or worse indicates "Here for etoh (alcohol) abuse and inappropriate." The record shows that the recipient was administered Haldol 5 mg and Ativan 1 mg at 3:05 p.m. "for loud aggressive behavior." There is no indication from the record that the recipient provided consent for the medication or that she was given the opportunity to refuse medication. She then fell asleep and was awakened at 7:25 p.m. for her psychiatric evaluation. The record also contains a certificate signed by a physician at 7:35 p.m. which indicates that the recipient is reasonably expected to engage in dangerous conduct, is unable to provide for her basic physical needs, and is in need of immediate hospitalization. The examiner has signed the statement that the recipient was told she did not have to speak with him and that her statement could be used in a judicial hearing. The clinical observations/factual information on which the diagnosis is based states, "Acute psychosis/Auditory Hallucinations, delusions of grandeur." The document that is the Rights of Individuals Receiving Mental Health and Developmental Disability Services is signed and dated by both the staff and the recipient. The record then indicates that the recipient was medically cleared at 9:55 p.m. The crisis worker is notified at this time and at 12:30 a.m. the record shows that the recipient was assessed and the decision made to admit her to the psychiatric unit which occurred at 6:00 a.m. on 10/06/09.

Loretto representatives were interviewed regarding the ED record. They indicated that the recipient came into the department very intoxicated and was very loud and uncooperative. Generally when patients come into the ED they are triaged, and if they arrive on a petition for involuntary admission, then the crisis worker will review the petition and assess the patient for mental health needs. Psychiatrists from the hospital behavioral health unit are on-call for consultation in the emergency department and the psychiatrist along with the emergency room physician make the determination for the need for mental health hospitalization. Hospital representatives indicated that emergency room staff are trained at least yearly on disability rights and due process.

Once admitted to the behavioral health unit, the recipient completed an application for voluntary admission at 7:45 a.m. on 10/06/09. The admission document indicates that the recipient's rights were explained to her and she received a copy of her rights information. The recipient also indicated that she wanted no one notified of her admission.

The record shows that the recipient received a psychiatric evaluation by her attending physician at approximately 4:30 p.m. on 10/06/09. The evaluation indicated that the recipient is receiving specialized medical care and is currently being treated at a special medical center, where she has her own physician and a regimen of medication. The evaluation indicates that the physician explained all side effects, risks and benefits of the prescribed medication and treatment, and that the recipient was agreeable to the plan. There is also a History and Physical Examination document completed by the certifying physician which indicates that the recipient

is prescribed numerous medications and that the medical center where she is treated will have to be contacted for the medication plan. Staff indicated and the record shows that indeed, the recipient's physician was consulted, and the specialized medications (Truvada, Lexiva, Norvir, and Bactrim) were ordered that were prescribed by the recipient's physician. Other psychotropic medications, such as Paxil, Ativan, and Trazadone, were ordered for the recipient by her physician at Loretto, however the progress notes (10/10/09) and Medication Administration Record indicate that the recipient refused this medication because it was not prescribed by her regular physician, and she stated that she would refuse any medication that had not been prescribed by her specialists (progress notes 10/11/10).

Progress notes entered on 10/07/09, 10/08/09, 10/12/09, and 10/13/09 indicate that the recipient was seen by her attending physician for individual therapy.

Hospital representatives were interviewed about the recipient's ability to contact the persons of her choice. They indicated that phones are available for recipients to call anyone of their choosing at any time outside of group time. Ordinarily there are three opportunities through the day to make phone calls and these are the periods after each meal. There are phones available in the hallway and at the nurse's station (with a cord long enough to reach an adjoining room for privacy) and the Guardianship and Advocacy Commission poster is displayed on the wall for access to contact numbers. The hospital staff confirmed that the phones were fully functioning at the time of the recipient's treatment episode for her to call her physician, family, friends or anyone of her choosing, or to ask for staff assistance in making calls.

Hospital representatives were interviewed about the allegation that staff told the recipient if she did not take her medication she would be sent to a state mental health facility. They responded (and the record confirms) that the recipient had a regimen of care from her medical specialists that she adhered to throughout her stay at Loretto and she generally refused all medication that was not prescribed by her regular physician, who was consulted by her Loretto treatment team. Although staff may have encouraged the recipient to take the prescribed medication, it was generally known that the recipient would continue with the plan of care as prescribed by her specialist.

Hospital representatives confirm that there is a hospital Complaint Officer who is available to advocate for patients, and that the name and number of this person is included in the patient brochure that is given to patients at admission.

STATUTORY BASIS

The Mental Health and Developmental Disabilities Code describes a "mental health facility" as "...any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons" (405 ILCS 5/1-114).

The Mental Health Code states that when a person is asserted to be in need of immediate hospitalization, any person 18 years of age or older may complete a petition (5/3-600), which specifically lists the reasons (5/3-601). The petition is to be accompanied by the certificate of a

qualified examiner stating that the recipient is in need of immediate hospitalization. It must also contain the examiner's clinical observations and other factual information that was relied upon in reaching a diagnosis, along with a statement that the recipient was advised of her rights (3-602). The Code also mandates that before the examination for certification the recipient must be informed of the purpose of the examination, that she does not have to speak with the examiner, and that any statements she makes may be disclosed at a court hearing to determine whether she is subject to involuntary admission (5/3-208). Upon completion of one certificate, the facility may begin treatment, however at this time the recipient must be informed of her right to refuse medication (3-608). As soon as possible, but no later than 24 hours after admission, the recipient must be examined by a psychiatrist or released if a certificate is not executed (5/3-610).

The Mental Health Code states that any person 18 years or older who is seeking admission as a voluntary recipient, any interested person 18 or older at the request of the person seeking admission, or a minor 16 or older, may execute an application for admission as a voluntary recipient.

The Mental Health Code states that upon admission, the recipient will be asked if she wants anyone notified of her admission, and if she does, the facility must immediately attempt to make phone contact with at least two of the designated persons or by mail within 24 hours (405 ILCS 5/2-113). Upon commencement of services the recipient or her representative must be informed of her right to designate a person or agency to receive notice when her rights are restricted (5/2-200), and whenever a person is admitted, the recipient must be given the phone number of the Guardianship and Advocacy Commission and if the recipient requests it, the facility must help her contact them (5/3-206). Also, the recipient must be allowed to make telephone calls to two persons at the time of her admission to such persons as she chooses (5/3-609).

The Mental Health Code mandates that within 72 hours after a recipient is admitted to a mental health unit the facility shall provide or arrange for a comprehensive physical, mental and social examination. This examination is then used to determine whether some program other than hospitalization will meet the needs of the recipient, with a preference given for treatment in the recipient's home or community (5/3-205.5).

The Mental Health Code states that an adult recipient of services must be informed of the right to refuse medication. The recipient 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).

The Mental Health Code states that whenever any rights of a recipient are restricted, the person responsible for overseeing their services plan shall give prompt notice of the restriction to the recipient, a person designated by the recipient, the facility director, the Guardianship and Advocacy Commission, and the recipient's substitute decision maker, if any. This person is also responsible for recording these restrictions in the recipient's record (5/2-201).

The Mental Health Code states that every recipient of services shall be free from abuse and neglect (405 ILCS 5/2-112).

## HOSPITAL POLICY

Loretto Hospital policy #IPU 1502.5 ensures that all involuntary patients are admitted within the guidelines of the Mental Health and Developmental Disabilities Code. It states that

"An involuntary admission is any person … subject to involuntary admission status because that individual is in need of immediate hospitalization for the protection of self or others from physical harm." Policy # IPU-1502.4 states that all voluntary patients will be admitted within the guidelines of the Mental Health Code. It states that patients will be assessed and determined clinically suitable for voluntary admission. Additionally, it states that all patients admitted on a voluntary status will have the Rights of Individuals communicated to them orally and receive a copy of them, and also receive a copy of the voluntary admission form.

Loretto Hospital policy #IPU-1500.1 states that "Loretto Hospital shall provide all rights to patients pursuant to the Illinois Mental Health Code and shall only restrict those rights to protect the patient or others from harm. All staff will know the rights and the procedures and standards for restricting those rights." The policy also states that upon commencement of services or as soon thereafter as the patient's condition permits, a staff nurse must orally review the rights with every patient or patient's guardian. Whenever any of the patient's rights is restricted, the policy requires written notice of the restriction be given to the patient, the guardian, the persons designated by the patient, an agency designated by the patient, the facility director, and any agency or attorney in fact under a Mental Health Preference Declaration or a Durable Power of Attorney for Health Care. Emergency medication may only be administered when such services are necessary to prevent the patient from causing serious and imminent physical harm to himself or others (#IPU- 1500.5).

Loretto Hospital Policy #IPU-1500.3 states that patients may communicate with persons of their choice by telephone "subject to reasonable time and place limitations established by the facility director." Newly admitted recipients are allowed to make at least two phone calls at the time of admission. Phone calls may be restricted only if calls are harmful, harassing, or intimidating to the recipient or others. If the use of telephones is restricted, a Restriction of Rights form must be completed to indicate the reason for the restriction.

## CONCLUSION

The complaint in this case alleged that the recipient was not evaluated in the 8 days in which she was a resident at Loretto, that she never saw a physician, was not given her rights or allowed to speak with an advocate or her own physician, and told that if she did not take her medication she would be sent to a state mental health facility. The HRA cannot substantiate these allegations, however in our role as advocates for people with disabilities we are compelled to point out that this recipient was denied her rights as a mental health recipient at Loretto Hospital.

The recipient in this investigation arrived at Loretto at 3:05 p.m. on 10/05/09. Immediately (3:05 p.m.) she was administered emergency psychotropic medication, even before she was medically or psychiatrically evaluated. Even though the recipient arrived on a petition for involuntary admission, the HRA hopes that this is not an automatic injunction to administer forced psychotropic medication. The statement of the petition indicates, "Client presents a psychosis. Client is hallucinating and delusional. Client poses a risk to herself and others. Client is combative and uncooperative." Other descriptions taken from the ED record describe the recipient as "loud", "talking loudly", "flight of ideas", "uncooperative with medical exam." The

reason given for the forced emergency medication is "loud, aggressive behavior." Never does the record describe any behaviors that would indicate an imminent threat of serious physical harm and thus a rationale for denying the recipient the right to refuse medication.

The HRA does not substantiate the allegations that the recipient was not evaluated in the 8 days in which she was a resident at Loretto, that she never saw a physician, was not given her rights or allowed to speak with an advocate or her own physician, and told that if she did not take her medication she would be sent to a state mental health facility.

SUGGESTIONS

1. Remind staff that they must not override the recipient's right to refuse treatment unless it is necessary to prevent serious and imminent physical harm and no less restrictive alternative is available, and it is documented in the clinical record.