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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 10-030-9019
CHICAGO LAKESHORE HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) 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 did not follow Code procedures when it detained a recipient and administered forced psychotropic medication. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Lakeshore is a 147-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 Program Director, and the Medical Director. The HRA obtained the recipient's record with written consent. The recipient is an adult who maintains his legal rights.

COMPLAINT SUMMARY

The complaint alleges that a voluntary recipient was held for three weeks after submitting a written request for discharge and was then discharged the same morning as his judicial hearing for involuntary commitment. Also, the complaint states that the facility administered forced psychotropic medication for no adequate reason.

FINDINGS

The record (Lakeshore Face Sheet) shows that the recipient was voluntarily admitted to the Intensive Treatment Unit at Lakeshore on 1/07/10 after being transported involuntarily from a hospital emergency room. The Intake Assessment states, "Pt. was transferred from …due to being agitated and making hostile threats to the staff. Pt. states that he wanted a pass and the staff was giving him a hard time. Pt. states that he became upset, because he felt that staff was giving him a hard time. Pt denies S/I [suicidal ideation], H/I [homicidal ideation], and psychosis at this time. Pt. is not experiencing any A/H [audio hallucinations], or V/H [visual

hallucinations] at this time. Pt. presented with a flat affect at this time." The Intake Mental Status Examination states that the recipient is "cooperative", his thought process is "normal" with no delusions.

The Initial Psychiatric Evaluation (completed 1/07/10) is included in the record. It states, "The patient is a 23-year-old African American male with a history of schizoaffective disorder admitted from… via …emergency room secondary to increasing psychosis and agitation. The patient was threatening staff when not immediately allowed a pass. The patient also is not taking his medications. UDS was negative and blood alcohol level was negative. The patient called 911, repeatedly clenching his fist and admitted for stabilization and protection of self and others." The Mental Status Examination states, "Appearance-the patient is neat. Behavior is guarded. Eye contact is fair. Motor activity is normal. Movement disorder- none. Speech- rate is regular and volume is normal. Cognitive functioning- orientation to time, place, person and situation. Memory is fair. Attention and concentration are fair. Intelligence is average. Thought process is goal directed. Thought content- no hallucinations. No phobias, obsessions, or compulsions. No suicidal ideation. He does not have access to a firearm. He does have some homicidal ideation threatening towards staff. Affect is labile. Insight is fair. Judgment is fair."

The record contains an application for voluntary admission signed by the recipient on Thursday, 1/07/10. The following day, Friday, 1/0810, the recipient requested and signed a Request for Discharge.

The record shows that the recipient was placed in restraints and administered forced psychotropic medication (Ativan 2 mg and Thorazine 100 mg IM) on 1/08/10 at 12:15 p.m. The Restriction of Rights document states the reason as: "Pt. verbally aggressive with staff. Unable to follow redirection, pt. swung at staff." The restraint flowsheet is included and indicates that the recipient was held in restraints for one hour and 20 minutes and monitored continuously. There is no mention of the episode in the Progress Notes, however the physician's notes state, "The patient is up in full restraints in a quiet room in the afternoon post escalating on the unit. The patient is still labile and delusional. He has poor insight into illness and problems leading to hospitalization. Continue to encourage medication compliance. Increase Seroquel to 100mg q. 12 hours and Haldol Decanoate 50 mg IM [intramuscularly] x 1." There is no physician's written statement of decisional capacity in the record and there is no document indicating the recipient's preferences for emergency intervention, if any.

The record (PRN administration record) shows that on 1/13/10 the recipient was again administered Ativan 2 mg, Thorazine 100 mg, and Vistaril 50 mg IM for "agitation." There is no accompanying Restriction of Rights document for this event and it is not mentioned in the Progress Notes.

The recipient's Discharge Summary describes the hospital course and medication regimen. It shows that the initial medications included Seroquel 50 mg every 12 hours, Trazodone 50 mg nightly, Thorazine 100 mg every 4 hours p.r.n. (per request), Vistaril 50 mg every 4 hours p.r.n., Ativan 2 mg every 4 hours p.r.n., Ambien 5 mg nightly, and Haldol 5 mg nightly. The record shows that the Seroquel and Haldol were increased during the recipient's stay, for whenever he would accept it. The record contains documentation of the recipient giving

informed consent for psychotropic medications Seroquel, Thorazine, Trazodone, Ativan and Ambien. The Medication Administration Record, Physician's Notes and Progress Notes (1/13/10, 1/14/10, and 1/22/10) all indicate that the recipient generally refused all of his psychotropic medication and that he told staff members that he would not take medication after discharge. Staff noted his non-compliance when the decision was made to discharge him on 1/22/10: "Spoke with Clinical Director re: attending physician's plan to discharge the patient over the weekend despite patient's history of non-compliance with meds and continuous refusal of patient to take meds on the unit. Dr … stated that the patient is not certifiable and that he is safe for discharge. Patient denies SI , HI, and any psychotic symptoms at this time. Discussion with the Clinical Director was communicated with the treatment team." For this reason he was discharged on 1/25/10, the morning of his judicial hearing, to himself with no order for medications.

The HRA requested a copy of the petition, certificate and hearing notice from the recipient's attorney. The petition was completed on 1/14/10 by a Lakeshore qualified examiner and gives as the reason: "Pt. is easily agitated without provocation verbally threatening staff and physical posturing with intent to physically harm staff. Pt. is harmful to self and potentially others." A certificate is included (1/14/10) which offers the following clinical observations/information: "Pt. was admitted to CLSH for agitation and threatening behavior. In his hospitalization pt. continues to be highly unpredictable anxious, agitated and threatening. Pt. has been refusing to take psychotropic medications that are offered to him and very resistant to treatment. Pt. had 1x incident of being restrained.,…[copy illegible]." A second certificate is attached which is dated 1/14/10 however the copy is illegible. The court order included with the petition indicated that the hearing was set by the court on 1/19/10 for a hearing on 1/25/10 and it indicates that the recipient was discharged on 1/25/10 and the order dismissed without a hearing.

Hospital staff were interviewed about the complaint. They stated that when recipients are admitted involuntarily they are generally offered an application for voluntary admission upon arrival to the behavioral health unit, which is what occurred in this case. After the recipient had signed a request for discharge, the patient was observed for the five day period and then it was determined that he was not appropriate for discharge and a petition and certificate were completed and submitted to the court. They were not able to supply a copy of these documents because a copy was not saved for the file, and thus there is no documentation in the record that these forms were completed or when. Staff stated that the petition and certificate were delivered the day they were completed and filed with the court. They also confirmed that these documents were formerly hand delivered by a messenger as in this case, but now they are faxed, and all original documents remain in the file. As in all cases the court sets the date for the hearing and staff have no control over the hearing date. They did report that if the hospital holds the recipient longer than the 5 day period, the court will dismiss the case and mandate that the recipient be discharged, thus there were continuances that were filed by the recipient's attorney, which are not in the record. Staff stated that now the commitment hearings are held at the facility and this ensures that documents are filed appropriately.

The staff were also interviewed about the administration of forced psychotropic medication. They stated that whenever they administer forced psychotropic medication a Restriction of Rights Notice is issued as it was in the restraint episode on 1/08/10. The

medication administered on 1/13/10 is then presumed to be at the recipient's request or with his consent. Staff were asked why the recipient would accept an injection of psychotropic medication when he generally refused all medications, and they stated that some recipients accept injections to receive faster relief of their symptoms even if they generally refuse medication. Staff were asked about a physician's statement of decisional capacity and preferences for emergency treatment and neither of these documents are part of the clinical record. Staff did report that the hospital policies are being changed to address both of these requirements. Additionally, staff reported that the recipient would definitely not be told that if he took an injection he would be discharged, especially since he was admitted voluntarily.

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 determines and documents in the recipient's medical record that the person (1) is clinically suitable for admission as a voluntary recipient and (2) has the capacity to consent to voluntary admission." (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." (405 ILCS 5/3-401). Upon the filing of the petition and first certificate, the court must set a hearing to be held within 5 days (5/3-611).

The Mental Health Code mandates that "Every mental health facility shall maintain adequate records which shall include the Section [Admission, Transfer or Discharge] under which the recipient was admitted, any subsequent change in the recipient's stats, and requisite documentation for such admission and status" (405 ILCS 5/3-202 a).

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 treatment and provides for their participation in this process to the extent possible, mandating an individual services plan with a periodic review of the plan and input by the recipient. Also, the recipient's preferences for emergency interventions are to be noted in the plan. If services include the administration of psychotropic medication, the physician must advise the recipient in writing of the side effects, risks and benefits of the treatment as well as alternatives, and must determine and state in writing whether the recipient has the capacity to make reasoned decisions regarding the treatment. If the recipient lacks decisional capacity the treatment may only be administered in case of an emergency or pursuant to a court order (405 ILCS5/2-102).

Should the recipient wish to exercise the right to refuse psychotropic medication, the Mental Health Code guarantees this right unless it is necessary to prevent serious and imminent physical harm to himself or others and no less restrictive alternative is available. If the recipient refuses this medication he must be informed of available alternate services and their risks as well as possible consequences of refusing 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, the facility director, and any person or agency the recipient designates, and it must be recorded in the recipient's record (ILCS 405 5/2-201).

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 him at all times unless he is secluded, and he is to be afforded his right to have anyone of his choosing notified (405 ILCS 5/2-108).

HOSPITAL POLICY

Lakeshore Policy #NS-37 Request for Discharge: 5/15 Day Notice states that all voluntary patients 12 years of age and older may request discharge. These patients are then to be discharged according to the Mental Health Code standards. The process for the filing and documentation of a request for Discharge states that:

1. If the recipient is a voluntary admission, the staff explain in writing and orally the process of the Request for Discharge and they offer a Request for Discharge form when requested by the recipient. A progress note is entered in the medical record documenting the process.
2. The physician is notified of the request and a sticker is placed on the face of the medical record indicating the date/time the request was signed.
3. The recipient is discharged at the appropriate time, or a petition and two certificates are filed with the court.
4. The request is maintained on the unit, and placed in the medical record upon discharge or when the request is retracted.

Lakeshore Policy #NS-65 states that all Restrictions of Rights, including restraints, are "instituted according to the Mental Health Code Standards." It states that the application of restraint is to manage behavior and its use signifies the imminent danger of the patient to himself or others and cannot be used to punish or discipline a patient or as a convenience to staff. Hospital restraint policy was reviewed and complies with the Mental health Code guidelines.

Lakeshore Policy #NS-68 Restriction of Rights indicates that all restrictions of rights, including medication against the recipient's will, must originate with a physician's order giving the type of restriction, the clinical justification for the restriction, and the duration of the restriction. It also states that a Restriction of Rights form is to be completed by the RN, and that the patient is to be notified verbally and in writing of such restriction. Also, policy states that the patient must be asked if he/she wants a copy of the form sent to another party. A copy of the form is then given to the patient and one copy is sent to Medical Records, where copies are made and sent to the persons indicated by the patient and also to the Medical Director.

Lakeshore Hospital Policy #NS-43-A indicates that every patient has the right to refuse medication and that this refusal must be noted in the progress notes. If a recipient refuses medication it will not be given "unless deemed necessary to prevent the patient from causing serious harm to himself or others; in which case the attending physician is notified." A Restriction of Rights Notice is completed for each episode of forced medication.

CONCLUSION

The patient was admitted as a voluntary recipient on 1/07/10 and signed a request for discharge the following day. Excluding the weekend days, he was held for 5 days and then petitioned and certified for involuntary admission on 1/14/10 and this documentation was submitted to the court (hospital staff recipient's counsel confirmed that the court would not accept a petition that was beyond the 5 day limit). The court documentation shows that the hearing was set on 1/19/10 for a court date of 1/25/10 and then the hearing was cancelled due to the recipient's discharge earlier in the morning on the same day. Although the time frame for the processing of the petition and certificates appears to be in order, the HRA was unable to obtain the legal documents regarding the petition, certificate and Notice of Hearing from the medical record, which violates both Mental Health Code and hospital requirements for the documentation of admission status. The HRA substantiates the complaint that the hospital did not follow Code procedures when it detained the recipient.

The restraint (1/08/10) and forced psychotropic medication (1/13/10) events are puzzling. The physician's order for restraint does not state the events leading up to the need for restraints, so we are left wondering what happened to cause the recipient's verbal aggression, and we are not told why he swung at staff or if it was a reaction to being restrained and force medicated. There are three entries in the progress notes for the day of the restraint however none of them describes the situation involving the restraint. The facility does not have a Preferences for Emergency Treatment form so it is unclear what less restrictive measures were attempted or considered. The medication issue on the 13th is listed as a prn injection that was given for "agitation." Staff indicated that since there was no Restriction of Rights Notice issued that the recipient requested or accepted the medication. Ordinarily this might be plausible, however in this case the recipient refused almost all of the medication that was offered to him and was even discharged for medication non-compliance. Also, there is no physician's written statement of decisional capacity in the record and there is no document indicating the recipient's preferences for emergency intervention, both Code mandates for the administration of psychotropic medication. The HRA substantiates that the hospital did not follow Code procedures when it administered forced psychotropic medication.

RECOMMENDATIONS

1. Ensure that clinical records include documentation which reflects the recipient's admission status and any subsequent changes.

2. Train staff on the Mental Health Code and hospital policy regarding psychotropic medication. Ensure that recipients are informed of their right to refuse medication. If the

recipient's services include the administration of psychotropic medication, ensure that the physician advises the recipient in writing of the side effects, risks and benefits of the treatment as well as alternatives, and determines and states in writing whether the recipient has the capacity to make reasoned decisions regarding the treatment. If the recipient lacks decisional capacity, ensure that the treatment is administered only in case of emergency or pursuant to a court order.

3. Instruct staff to ask all recipients for their preferences for emergency intervention and include any designations in respective treatment plans.