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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9004
WESTLAKE 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 Westlake Hospital. It was alleged that the facility did not follow Code procedure when it admitted a recipient and denied her the medication prescribed by her physician. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.).

Westlake Hospital is a community hospital and now a member of Vanguard Health System. The 120-bed hospital incorporates a 29-bed Behavioral Health Unit.

To review these complaints, the HRA conducted a site visit and interviewed the Chief Nursing Officer, the Director of Nursing and the Nurse Manager of Behavioral Health. Relevant hospital policies were reviewed, and records were obtained with the consent of the recipient. The recipient is an adult who maintains her legal rights.

COMPLAINT SUMMARY

The complaint states that the recipient asked upon admission if she could leave against medical advice. Allegedly, staff told her that if she left it would be "very expensive for you" because insurance would not cover the expense. Because of this reason the recipient agreed to remain in treatment. The complaint also states that the recipient's family asked for the Petition for Involuntary Admission three times because they were given incomplete and outdated versions of the form and were not given the current Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form. Additionally, the complaint states that the hospital denied the recipient her medication for manic depression and then held her because she was "manic".

FINDINGS

The record shows that the recipient was admitted to the Westlake Intensive Care Unit (ICU) at 2:50 p.m. on 8/8/10 by her husband. She had earlier taken an overdose of Xanax which was interpreted as a suicidal gesture. The recipient's Discharge Summary describes her presenting problem: "This is a 41-year-old married, white female who was admitted to the Intensive Care Unit after ingesting 15 tablets of Xanax 'to escape'. This was seen as a suicidal gesture. The patient had not done well for the past three months because of stresses in her life including:

1) Ongoing marital problems
2) Starting a new job
3) Psychiatrist on vacation, she last saw her therapist on the preceding Saturday."

The record shows that the recipient was placed on a 23-hour observation, given activated charcoal, and administered diagnostic tests along with a psychiatry consultation while in the ICU. She was diagnosed with Depression and Bi Polar Disorder. She was then recommended for psychiatric admission and was transferred to the Behavioral Health Unit on 8/09/10 at 4:00 p.m. At this time the recipient also completed an Application for Voluntary Admission and was given the Rights of Voluntary Admittee form.

The record contains the Petition for Involuntary /Judicial Admission (pages 1 and 2 are 2004 version and pages 3, 4, and 5 are 2008 version) completed at 3:00 p.m. on 8/09/10. It indicates that the recipient is mentally ill and is reasonably expected to inflict serious physical harm to herself and is in need of immediate hospitalization. This assertion is supported by the following description of signs and symptoms of mental illness: "Patient is depressed. Undergoing stress took overdose of Xanax 15 tabs after fight with husband. Pt. is a suicidal gesture and in threat of marital breakup." The admitting nurse has certified on this form that the recipient has been given a copy of the petition and an explanation of her rights, and has been provided with a copy of the Rights of Individuals Receiving Mental Health and Developmental Services. Page 4 has a handwritten statement that "Petition and certificate given to the patient." The certificate, completed by the consulting psychiatrist on 8/09/10 at 1:30 p.m., is included in the record and offers the following clinical observations: "Pt. is depressed, undergoing stress, took an overdose in a suicidal gesture 'to escape'". The record contains a Rights of Recipients of Mental Health and Developmental Disabilities form which the admitting nurse has certified that it has been explained to the recipient and a copy placed in the record. There is also a Signature Page in the record with the recipient's signature and witness signature stating that she received a copy of the rights information.

The record contains an admission note which indicates that the recipient was prescribed the following medication from her outpatient psychiatrist: Lithium, Wellbutrin, Lamictal, Klonipin, Geodon, and Lexapro. These medications were ordered by the Westlake physician (the recipient's signed informed consent for all medication is included in the record) except that Geodon and Trazodone were ordered "as needed" for agitation or anxiety. On 8/08/10 and 8/10/10 lab tests were completed to determine blood levels of Lithium and on 8/11/10 the Lithium medication is revised to an increased extended release form. The medication rationale is described in the Discharge Summary: "The patient was placed on suicidal precautions and close observation. Individual therapy, group therapy, AT [art therapy], RT [recreation therapy], and comprehensive inpatient was given. Her Lithium level on 900 mg per day was 6. An additional

300 mg was given. On day three, which is today, the Lithium level was 1.0. It probably might not be at a steady rate yet. She is to have the Lithium level repeated on Monday 8/16/10. I have also educated the patient as to the signs of too high Lithium dose level." In the Discharge section the physician notes state that the patient is to take her prescription of all her medication to her psychiatrist after she is released. The recipient signed a request for discharge on 8/11/10 and was released on 8/14/10.

Hospital staff who interacted with the recipient on the day of her admission were interviewed about the complaint. They stated that it would be very unusual for staff to tell a recipient that if she left against medical advice it would be more expensive for her, as this is not the responsibility of nursing staff. They stated that patients are allowed to leave at any time unless they are deemed a danger to themselves or others, and then a petition is completed as it was in this case. The patient in this case was brought to the ITU because of a drug overdose and because this is viewed by staff as an acute medical event, all the treatment that is offered is to stabilize the patient. While the patient was being treated for her medication overdose, the consulting psychiatrist recommended inpatient treatment, and at this time the petition was completed. Staff recalled the recipient and her presentation in the ITU and they did not remember that the recipient requested to leave. Staff did recall that the husband and mother of the recipient were very preoccupied with and focused on the admission documents that the recipient was presented. Staff presented the recipient with several versions of the documents until the family was willing to accept them, however the family was not satisfied with the resultant forms. Staff members were surprised at the focus placed on the versions of the documents offered, since the recipient was being admitted for a suicide attempt. There is no Release of Information in the record for the family.

Staff reported that at time of this incident the hospital had just become part of a new medical group, Vanguard Health System, and that every form was being revised to reflect the new owner. Most of the hospital forms had been modified to reflect the new owner, however this extensive revision may have brought previous editions of the documents forward. The staff confirmed that all the documents have now been revised and the updated versions are in use.

Hospital staff reported that the treatment plan for the recipient was always that she would return to her own medication after the treatment of her acute symptoms. The only change from her regular medications was the increase of Lithium and the change from its regular form to the extended release form and this was based on the patient's blood level which was tested for therapeutic level on two occasions. Hospital staff stated that the recipient did not object to her medication regimen when she was a patient. Also, they stated that the patient was not held because she was manic and she did not display manic behaviors. Staff confirmed that she was treated until her symptoms were stabilized and she was then released to her physician's care, as recorded in her clinical record.

STATUTORY BASIS

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 (405 ILCS 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 certain rights (3-602), including that before the examination for certification the recipient must be informed of the purpose of the examination, that he does not have to speak with the examiner, and that any statements he makes may be disclosed at a court hearing to determine whether he 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 his 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 age 16 years or older may apply for admission as a voluntary recipient for treatment of a mental illness upon the filing of an application with the facility director 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. A person has the capacity to consent to voluntary admission if, in the professional judgment of the facility director or his or her designee, the that person is able to understand that he or she is being admitted to a mental health facility, that he or she may request discharge at any time, and that within 5 business days after receipt of the request, the facility must either discharge the person or initiate the commitment process. (405 ILCS 5/3-400).

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…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. The facility director shall inform a recipient…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).

HOSPITAL POLICY

Westlake Hospital policy for Inpatient Behavioral Health Services outlines the specific criteria necessary for a person to be admitted to the Behavioral Health Unit. Included in these criteria is a physician's evaluation and determination that the person has a primary diagnosis or provisional psychiatric diagnosis, that the person cannot be appropriately treated at a less intense level of care, and that the severity of the illness presented by the person poses a significant risk of harm to the person or others. The policy mandates a physical examination be conducted within 24 hours after admission, and a psychiatric examination within 24 hours after admission.

Any person 18 years and older can apply for admission as a voluntary patient upon filing an application at Westlake Hospital. After the patient has been assessed, the attending psychiatrist determines the need for voluntary admission by medical order. Voluntary patients are to be discharged at the earliest appropriate time, not to exceed five working days, after giving written notice of their desire to be discharged.

The discharge from inpatient care is determined by the patient's symptoms that necessitated admission- when they have lessened or diminished in severity to the extent that the symptoms can be managed at a less intensive level of care, when the improvement in symptoms and functional capacity has stabilized, when the person no longer poses a threat to themselves or others, and there is a viable discharge plan, then the person is recommended for discharge. It is also possible for the person to withdraw from treatment against medical advice and their treatment is discontinued if they do not meet the criteria for involuntary commitment.

CONCLUSION

The record indicates that the recipient was admitted into the Intensive Treatment Unit at Westlake Hospital after a possible suicide attempt on 8/08/10. The record indicates while she was in the ITU she was assessed by a psychiatrist and petitioned and certified for involuntary admission. The record shows she was admonished of her rights and then admitted to the Behavioral Health Unit on 8/9/10. She then signed herself in as a voluntary recipient and subsequently requested discharge on 8/11/10. She was discharged on 8/14/10. Although the forms that were utilized to petition and certify the recipient were not the latest editions, the documentation suggests that the Code's intended processes and protections were followed. There is inadequate evidence to show that the recipient remained in treatment because she was told that it would be more expensive to leave. The HRA does not substantiate the complaint that Westlake Hospital did not follow Code requirements when it admitted the recipient.

The HRA cannot judge the medical regimen prescribed by the recipient's attending physician, but only review the process as it comports with Code requirements. The record indicates that the recipient was given the same medication as she was prescribed in outpatient therapy except that the Lithium was revised from its regular form to the extended release form and this was based on the patient's blood level which was tested for therapeutic effectiveness on two occasions. This follows the physician's protocol which was outlined in the clinical record. All medications had the signed informed consent of the recipient and there was no indication from the record that the recipient refused medication or was given forced medication. Additionally, the recipient was not held by the hospital because she was manic, but until her symptoms stabilized, and she was then released. The HRA does not substantiate the complaint that Westlake Hospital denied the recipient the medication prescribed by her physician.

SUGGESTIONS

1. Ensure that staff utilize the latest forms for all admission documents as available on the Illinois Department of Human Services website at: http://www.dhs.state.il.us/forms.

2. Absent a legal guardianship or an advanced directive for someone with documented decisional incapacity, secure recipient written consent before disclosing recipient medical or mental health information and before involving family members in treatment.