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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 11-030-9005
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 administered forced psychotropic medication 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 147-bed private psychiatric hospital located in Chicago.

To review this complaint, the HRA conducted two site visits and interviewed the Director of Risk Management, the Program Director, the Director of Clinical Services, the registered nurse on duty at the time of the incident, and a mental health counselor. 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 on October 10th, sometime after 1:00 a.m., two male staff entered the room of the female recipient and asked her to follow them down the hall. The recipient had been playing cards on her bed at the time, and she asked the staff what was happening and if she could trust them. They said of course she could trust them and she left the room with them and followed them to the "green" room, also known as the quiet room. The complaint alleges that the staff left the recipient in the room and left, while the recipient was thinking that perhaps they were getting her belongings because she was packed to go home. When the staff returned to the room they allegedly threw the recipient down on the bed face down. The complaint states that staff then took out a syringe, held the recipient down, and injected her in her buttocks while she continued to protest. They then left the room. The complaint alleges that the recipient attempted to stay awake by praying and then by speaking into the camera that was on the wall, fearful of what might happen to her if she lost consciousness, however she became so tranquilized that she fell asleep. In the morning the recipient allegedly

woke in her own bed, and she did not remember being awakened or seeing the staff again since they first left the quiet room.

The complaint alleges that the recipient reported the injection incident to her social worker who told her to report it to the Program Director. The recipient allegedly called the Program Director on 11/12/09 and on 11/16/09 and left lengthy messages on her answering machine regarding the event. Later, the Program Director called the recipient and again the recipient reviewed the complaint and allegedly she was told by the Program Director that the situation would be investigated. The recipient did not receive a response from the facility.

FINDINGS

The Lakeshore admission Face Sheet indicates that the recipient was admitted on 10/06/09, brought to Lakeshore by the police department on a petition for involuntary admission completed by the recipient's psychologist. She was placed in a 23-hour observation bed and then transferred to the inpatient Intensive Treatment Unit (ITU) on 10/07/09. The Presenting Problem/Reason for Hospitalization section of her Discharge Summary states, "The pt. is a 35-year-old Caucasian female who was admitted for hypersexual behavior. She threatened to kill herself. She reports knowing where the gun is that she could kill herself with…She is very psychotic feeling grandiose, hyperverbal, and labile…she threatened to kill herself and throw herself from the window. She reported knowing where the gun is to shoot herself. She is paranoid, delusional, hyperverbal and manic." While in the special observation bed the recipient received a Medical History and Physical Examination along with an Intake Assessment. In the History section of the assessment it states, "35 year old female presented to CLSH via CPD due to pt. exhibiting bizarre and psychotic behaviors. Per petition 'Pt. presented to agency to see psychiatrist and started throwing furniture, stripped down to her waist, and started being sexually inappropriate. Pt. threaten [sic] to kill herself, throw herself from window and reports knowing where a gun is.' During assessment pt. was paranoid, delusional, hyperverbal, and manic. Pt. reports being raped fourteen times all over the world. Pt. also believes she has super powers to disappear. Pt. denies HI/SI/AH/VH [homicidal ideation/suicidal ideation/audio hallucinations/visual hallucinations] at this time. Pt. also denies any drug or alcohol use." At the end of the 23- hour observation, the summary noted that the recipient was still psychotic and attention seeking, and she was then admitted to the Intensive Treatment Unit.

The record contains a petition for involuntary admission completed on 10/06/09 (time not given) by the recipient's case manager. The statement of the signs and symptoms of mental illness states, "Client showed at agency to see psychiatrist. Client started throwing furniture, stripped down to her waist. Client was being sexually inappropriate. Client reports she wants to kill herself, throw herself from the window, reported she knows where a gun is." The petition is accompanied by the Rights of Recipients of Mental Health and Developmental Disabilities Services form and this form is stamped "Involuntary Patient Received Rights." The Risk Manager stated this stamp is used for those recipients who refuse to sign or cannot sign their rights documents.

The first certificate, completed on 10/06/09 at 3:40 p.m. by the Intake Clinician states that "The pt. is acutely manic, hyperverbal, disorganized and delusional. She also endorsed suicidal ideations in her psychiatrist's office today. Pt. is unable to make safe decisions regarding her wellbeing and is in need of psychiatric stabilization at this time". The qualified examiner has certified that the recipient was informed of the purpose of the examination, that she did not have to speak with the examiner, and that her statements could be used in mental health court to determine if she is in need of involuntary treatment. The second certificate, completed on 10/06/09 at 7:20 p.m. by the psychiatrist, states, "35 yr. old white female with history of BPDO [bipolar disorder] with history of noncompliance with meds. Presented with increased psychosis…per petition patient has been stripping down to waist displaying aggressive behavior/throwing furniture, throwing her out of window." This document also certifies that the recipient has been orally informed of her rights and that she received a copy of the Rights of Recipients.

There are two entries in the progress notes for the day that the recipient allegedly received injections of medication. The first entry is made at 12:00 p.m. It states, "Alteration in Mood/manic. 'Today feels like a beautiful day. Hopefully I'll be leaving soon'. Pt. attended groups and socialized with peers in the dayroom. Bright affect, pt. made above statement when approached. Encouraged pt. to continue being medication compliant and approach staff when feeling the need to talk." The second progress note entry is made by the recipient's physician at 3:10 p.m. It states, (in part it is illegible) "Poor social boundaries, hyperverbal, intrusive, grandiose, alert and oriented, disheveled, unkept." There is no indication from the progress notes of any incident requiring the administration of forced medication for the recipient, and no Restriction of Rights Notice was issued.

The record contains the PRN (as needed) Medication Administration Record. The record shows that on 10/10/09 at 1:00 a.m. the recipient was administered three injections: Ativan, 2 mg for agitation, Haldol 5 mg for agitation, and Cogentin, 1 mg for reason illegible. There is a Physician Medication Statement Sheet which indicates that someone (patient, parent/family, guardian not checked) was given the benefits, risks and alternatives for two medications, Ativan and Ambien on 9/18/09 (it is not known why this date is on the form- the recipient was not admitted until 10/06/09). There is a physician's order for Ativan 2 mg po/im (oral or intramuscular) for "agitation" written 10/06/09. The Current PRN Medication Ordered sheet indicates the start date as 10/06/09 and the stop date as 10/12. The PRN Administration Record shows that on 10/06/09 the recipient received Ativan 2mg at 9:30 a.m. The record also contains a physician's order for Haldol, 5 mg, Ativan, 2 mg, and Cogentin, 1 mg, all po/im for "agitation", except for the Cogentin which was given for side effects written on 10/07/09. The start date is listed as 10/07/09 and the stop date is listed as 10/07/09 for the Haldol and Cogentin and 10/14 for the Ativan. The PRN Administration Record does not show an administration of these medications on 10/07. There is no entry on the Current PRN Medications Ordered sheet for the medications given on 10/10/09 however they are listed in the PRN Administration Record at 1:00 a.m. The record does not contain a physician's written statement of decisional capacity for this recipient. Additionally, there is no identified Preferences for Emergency Treatment in the record.

The recipient's progress notes indicate two incidents of refusal of medication: Tegretol on 10/08/09, and Seroquel and Trileptal on 10/09/09, both of which correspond with the Administration Record.

Hospital staff were interviewed regarding the complaint during two site visits to the facility. Initially, the Director of Risk Management was not aware that this complaint had been filed internally however she stated that the Program Director is the frontline person for handling this type of complaint and that the Program Director would investigate and report to the Director of Clinical Services, who would fully investigate. The Program Director stated that the recipient was acutely symptomatic (delusional) when she arrived and did not want to be in the hospital. She stated that an emergency injected medication would be administered based on the severity of the symptoms and that sometimes patients accept injections because they work faster and that this might have been the situation for this patient. She acknowledged that the recipient had made a verbal complaint regarding the isolation and medication event and that the Program Director had looked at the file and had interviewed one of the male staff members on duty the night of the event (the other staff member having resigned). There was no written report or response written to the complaint and no training or consequences for the staff. The Program Director stated that she attempted to call the recipient but did not reach her. Also, the Program Director stated that if she is given a complaint that she cannot resolve, it then goes to the Director of Risk Management. Staff were asked if the facility has a Patient Advocate as stated in the hospital policy and they stated that the Patient Advocate is the Director of Risk Management. The Program Director stated that she did not report the alleged incident to the Illinois Department of Public Health because she didn't feel that anything abusive had occurred. Staff felt that the time of the administration of medication does not suggest that it was not requested by the recipient, in fact, it might suggest that the recipient was having difficulty sleeping. Additionally, if it was requested by the recipient, nothing would be noted in the record.

On a follow-up visit to the facility the Director of Clinical Services was interviewed. Although she was not part of the investigation of this complaint, she stated that on viewing the record, she felt sure that the recipient did not refuse the medication, but requested it. She stated that patients often request injections and that if the medication had been forced, a Restriction of Rights form would have been completed. She stated that there would not have been any further documentation in the file if the injection had been requested. Staff were asked if the recipient gave informed consent for the medication and at this time they shared the form that shows Ativan and Ambien were discussed on 9/18/09. At this meeting staff were also asked if the recipient's complaint had been submitted both by phone and by written complaint and they indicated that it had been submitted both by phone and in a written form. Also, they indicated that the Performance Improvement Committee was not notified of the complaint.

The facility nurse who administered the three injections was interviewed about the complaint but he did not recall the recipient. One of the staff members on duty at the time of the event was also interviewed. He stated that he is not a nurse and would not have given an injection.

STATUTORY BASIS

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:

> "(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. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. 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.
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> (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 [an emergency], or 2-107.1 [a court order]…(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 is a serious and imminent physical threat of 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).

HOSPITAL POLICY

Lakeshore Policy #NS-69 states that all Restrictions of Rights are "instituted according to the Mental Health Code Standards."

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 Policy #ADM-005 Patient Grievance states that a Patient Advocate is appointed to receive, investigate, and respond to complaints from patients, their families, or others. The procedure for the grievance process is given to patients and their families at admission.

The Lakeshore policy states that staff will make every attempt to resolve problems that are brought to their attention. The hospital offers two ways in which grievances may be filed: from within the hospital the patient can dial extension 100, and outside the hospital can dial a number and ask for extension 100. If there is no satisfactory resolution of the problem, the person with the complaint is requested to put their complaints and suggestions in writing to the CEO, the Medical Director, or patient Advocate.

The Lakeshore policy states that written grievances will be processed as follows:

A. Follow-up will begin by the Patient Advocate upon receipt of the complaint. The Patient Advocate will interview all the individuals with knowledge of events surrounding the grievance. This will occur within 3 business days wherever possible, with all relevant information documented.

B. Based on the results of the investigation, the Patient Advocate will:

a. Take immediate steps to resolve or rectify the situation, or

b. Refer the issue to the appropriate management team leader for further analysis and appropriate action.

c. The Patient Advocate will respond to the person about the action being taken on his/her grievance, verbally and in writing within 7 days of the receipt of the complaint for significant issues. The written response must include: Hospital name, name of

contact person, steps taken to investigate complaint, results of complaint process, and date of completion.

d. Documentation of all grievances and the progress towards their resolution will be forwarded to the Director of Performance Improvement for review, and/or further action if needed. A summary of all written complaints will be reviewed quarterly by the Performance Improvement Committee.

C. Presentation of a grievance will not in itself serve to compromise a patient's future access to care.

D. The hospital will inform the patient that he/she may lodge a grievance with the Joint Commission, Illinois Department of Public Health and Centers for Medicare and Medicaid Services directly regardless of whether he/she has first used the hospital's grievance process.

CONCLUSION

The Mental Health Code mandates that in using psychotropic medication the facility must first secure informed consent, based on the written drug information that is shared with the recipient after a physician has stated in writing that the recipient has the capacity to make a reasoned decision about treatment. When psychotropic medications are refused, they may only be given to prevent serious and imminent physical harm. In this case the recipient states that she was given the medication against her will, in which case the hospital states, there would have been a Restriction of Rights Notice issued. In the absence of the notice, and any other documentation in the record of an outstanding event, we are to assume that the medication was a standing order (given the start and stop dates on the Current PRN Medication Ordered form) following the prescription dated 10/07/09. If so, there is no physician statement of decisional capacity, there is no valid informed consent, and the record does not contain preferences for emergency treatment, all requirements of the Code.

The HRA substantiates the complaint that the hospital administered forced psychotropic medication in violation of the Mental Health Code.

RECOMMENDATIONS

1. Develop policy and train staff in all the Mental Health Code requirements concerning psychotropic medication. Ensure that recipients are informed of their right to refuse medication, secure informed consent after reviewing the side effects, risks and benefits of the medication along with alternatives, include a physician's written statement of decisional capacity in the record, and include the recipient's preferences for emergency treatment where they can be accessed should the need arise.

SUGGESTIONS

1. The hospital record does not provide any information regarding the "agitation" that was the basis for the injections on 10/10/09. However if there was a complaint to the hospital by the recipient that included any hint of potential physical or emotional abuse such as that reported to the HRA, then the hospital should have been more intent on following established grievance

rules and procedures. The CMS' Conditions of Participation for Hospitals Section 482.13 (a-2), states the hospital must establish a process for prompt resolution of grievances, including written notification on steps taken to review the matter, results, and contact information. Additionally, the hospital in this case did not follow their own timeline set out in hospital policy for patient complaints, did not assign the hospital personnel to the investigation as outlined in their policy, and did not follow the documentation protocol as outlined in their policy. The HRA reminds Lakeshore for future reference that as of January 2010 hospitals are required to report all allegations of abuse of patients to the Illinois Department of Public Health (210 ILCS 85/9.6).

Train staff to follow hospital policy for the investigation of recipients' complaints and report all allegations of abuse to the proper authorities.