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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 16-030-9012
Methodist Hospital

Case Summary: The HRA did not substantiate the complaint that the facility did not follow Code requirements when it restricted a recipient's phone rights without adequate reason, administered forced emergency medication without adequate reason, did not obtain the recipient's consent for medication, did not investigate the attack of the recipient by other patients on the unit, and prevented the recipient from filing a grievance.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Methodist Hospital. It was alleged that the facility did not follow Code requirements when it restricted a recipient's phone rights without adequate reason, administered forced emergency medication without adequate reason, did not obtain the recipient's consent for medication, did not investigate the attack of the recipient by other patients on the unit, and prevented the recipient from filing a grievance. If substantiated, this would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Hospital Licensing Act (210 ILCS 85).

Methodist Hospital is a 168-bed medical-surgical facility with a 59-bed Behavioral Medicine Department which includes four inpatient units and an Intensive Outpatient Program.

To review these complaints, the HRA conducted a site visit and interviewed the Director of Behavioral Medicine, the Assistant Administrator, and the Attorney for Methodist Hospital. Relevant hospital policies were reviewed, and records were obtained with the written consent of the recipient.

COMPLAINT SUMMARY

The complaint alleges that the recipient's phone rights were restricted for no adequate reason, that he was administered forced emergency medication for no adequate reason, that he did not give consent for the medications he was given, that the facility did not investigate the attack of the recipient by other patients on the unit, and that the hospital prevented the recipient from filing a grievance.

FINDINGS

The record shows that the recipient was admitted into Methodist Hospital on 10/13/15 at 11:15 a.m. The Initial Psychiatric Evaluation completed on the same day states, "Pt is a 22 year old male referred from [area hospital] ER where he was taken by CPD after patient told friend that he wanted to die. He presented in [area hospital] with flight of ideas, loosening of associations. Stated he had thoughts of hurting himself and history of multiple suicide attempts in the past." The recipient was provisionally diagnosed with Bipolar I Disorder, manic with psychotic features.

Social Service notes from 10/13/15 state, "This LSW received a call from Assistant Dean at [area university] to inform this LSW of additional reasons for patient's admission. Per conversation, patient has history of manipulative behavior, minimizing and disrupting the [university] community. Prior to hospitalization, patient was posting extreme posts on Facebook that began to raise awareness for those suffering from mental illness. As the day went on, patient's Facebook page began to exhibit more severe and grandiose thoughts. Patient began making statement at 8:00 a.m. something is going to happen on campus. A later post stated. 'Pushed back until 12:00'. [University] students were becoming fearful of these posts, concerned that the patient may be homicidal. Several students contacted the dean's office regarding these Facebook posts. In 2014, patient left a suicidal Facebook post and was missing for over 48 hours. Patient has a history of going missing, suicide attempts and manic episodes. Patient is well known in the [university] community as well as in the dean's office…."

The record contains the Medication Consent Form for the recipient. It indicates that he gave written informed consent for the following medications: Ativan, Cogentin, Haldol, Thorazine and Trileptal on 10/13/15, Risperdal on 12/09/15, and Risperdal Consta on 12/18/15. The record shows that the recipient was prescribed the following psychotropic medications: Thorazine 400 mg each day at bedtime and 100 mg twice daily, and Trileptal 600 mg every 12 hours. The recipient was prescribed the following PRN (as needed) medications: Cogentin, 2 mg IM (intramuscular), Haloperidol Lactate 10 mg IM, Haloperidol 5 mg orally, Lorazepam 2 mg orally, and Lorazepam 2 mg IM. Physician notes indicate that the recipient's response to his medication order was that he acknowledged that he was medication noncompliant/under dosing, and that he requested Zoloft, which was not ordered "due to potential for activation." The record shows that the recipient frequently refused his medication. It is also noted that the recipient's medication regimen was a topic of treatment team discussion throughout his hospital stay and that his physician responded to his reactions to medications and the efficacy of his medications several times per week.

Psychiatric progress notes from 10/16/15 state, "Still expressing mania and grandiosity, 'You are ants to someone with my IQ.' Still expressing self harm although as means to manipulate medication treatment: 'I am refusing to take my [anti-viral] medications until you prescribe me Zoloft and this will be your responsibility.' 'Would you attempt to compete intelligently with Einstein or Beethoven? Then you shouldn't attempt to compete with me because I am just like them,'" Later in this note, "Complaint of verbal threat of physical violence for being gay from other patient. This could be manipulation and attempt to control treatment. Instructions given to staff to take this seriously and investigate." The physician Plan from this

note states, "…Discussed move to 5B with nursing staff and counselor to avoid altercation with other patient…" Social Service notes from 10/15/15 indicate that the recipient was moved to Unit 5 South. On 10/19/15 the notes show that he was then moved back to Unit 5B. Notes from that day state, "… This LSW was approached by patient several times throughout the day. Patient presents as psychotic and manic at the same time. Patient is extremely irritable, screaming at staff and patients, demanding that he is in control and people need to listen to him. Patient is non compliant with medication and treatment, appears paranoid that the hospital staff is trying to hurt him/take advantage of him. Patient continues to request grievance paperwork, reported this hospital to Equip for Equality. This LSW has been discussing this case with LCSW, Risk Management, Intake, RN Manager, and team of MD's. This LSW and Intake have been working together in transferring patient to other hospital, due to patient's non compliance with treatment. Patient continues to present as homicidal/suicidal, making threats that he will destroy others. Patient appears unpredictable, and is NOT stable for discharge to the community or to school at this time."

Nursing Notes from 10/19/15 state, "Pt seen in the milieu pacing, restless, intrusive, not able to follow directions, labile, provoking other patients, poor boundary, wandering into other patients' rooms and not able to follow direction. Staff made several attempts to have therapeutic communication with patient but not processing positively, presenting poor judgement and insight to his behaviors. Patient informed he will be given medication to keep him calm and thoughts better organized. Patient agreed and Haldol 10mg IM given on left deltoid at 9:47 a.m. Pt offered Cogentin 2 mg IM but strongly refused. Patient educated on the positive effects patient continues to refuse, stating, 'I cannot have 2 injections at the same time.' Patient however at this time not seen with any physical distress and will continue to observe." On 10/21/15 the recipient received another injection described in the nursing notes: "Patient extremely anxious, pacing in the hallways and while in the front of the staff talking, attempted to put himself on the floor, stated, 'Too much talking makes me dizzy.' Patient offered Ativan IM and accepted, given, tolerated well, patient continue to monitor on close observation for safety."

Psychiatric progress notes from 10/21/15 state, "Staff report: Patient pacing unit. Often getting into face of other patients. Manipulative telling one patient that another patient has specific plans to hurt them. Still expressing manic symptoms although improved; able to sit in chair during interview, most likely result of earlier administration of prn. Still attempting to control treatment. Took Trileptal this am but refusing other psychiatric medications. Still acting directive. Still unable to listen or rationalize. 'I am not manic. I am very intelligent and intelligent people have rapid speech.' Became distressed, crying, and fell to floor while this APN was on unit. Patient was able to explain this was caused by excessive worry about medications and fear of suicidality. 'I don't want to take these medications because they will make me suicidal; they have before.'"

Psychiatric progress notes from 10/22/15 state, "[Recipient] presented non compliant with medications after a period of compliance. 'The medications make me suicidal.' He has had episodes of suicidality whether on medications or not and he related he had suicidal ideas around age 6. Now he alters the story stating that he received medication in the second grade and became suicidal a year later. He is very inconsistent and not competent to decide on his medication. When confronted with our assessment that he is at risk to others or self he states,

'That is perfectly fine.' When informed of the facts that other people on campus of [area university] are scared he may hurt them he also relates, 'That is perfectly fine.' When informed of possible expulsion from [university] he relates, 'That is perfectly fine.' We will stop medications as he is clearly unable to judge the benefits or intended effects based on a preconceived notion that 'all medication therapies will cause him suicidal thinking' and that he will only respond to non medication alternatives. Next week will attend a hearing for involuntary medication and involuntary commitment."

Psychiatric notes from 10/26/15 state, 'Patient is still very manic. Patient brought written list of issues he wanted to cover. Complaint of not being able to make calls. Phone rights put on restriction per complaint from [his university] staff of multiple phone calls to staff. This APN is not aware of the specifics. Patient acknowledged he made calls to [university staff]. Reason for doing so was hard to follow." The following day the psychiatric notes state, "[recipient] seen and care reviewed with staff. He is still certifiable as he remains restless, pacing, manic, and growing level of psychosis today. Reviewed with him provocative behaviors in calling the Associate Dean at [his university] threatening to sue the school after being repeatedly told that she views him as a direct threat. Cannot process his impulse control problems. Seen pacing the unit telling staff I am threat to his and other patients' safety. Clearly remains psychotic and now bridging to paranoia." Psychiatric notes from 10/27/15 also address the recipient's phone restriction stating, "[Recipient] called to [his university] administration via phone yesterday to threaten lawsuits to them. Associate Dean called here requesting his calls be limited."

The record contains a Notice Regarding Restriction of Rights of an Individual document. It states that on 10/26/15 the recipient had his phone rights restricted due to threatening calls. The Notice indicates that it was given to the recipient and to two others who he identified.

The record contains a letter written by the recipient's attending physician summarizing the recipient's treatment episode for the mental health judge:

"[The recipient] was admitted to the hospital referred by [an area hospital] after concerns of a friend that he was at risk for suicide. Dr… performed a Psychiatric evaluation and found [the recipient] to be grandiose asking her to Google him for the details of his treatment history including multiple suicide attempts since second grade, multiple hospitalizations along with failed medication trials and his opinion that he is suffering PTSD. He went on to discount postings on the internet that panicked students on the [university campus] that he may do something harmful to the campus. He wrote something life changing would occur on the campus and gave warning to those interfering with his plan would suffer pain 'more than could be imagined.' He spoke rapidly and reported that he would stop any psychotropic medication which would make him feel suicidal and almost all of them did. He was diagnosed with Bipolar Disorder manic type with psychotic features (F31.2). Trileptal was prescribed as a mood stabilizer, Thorazine was ordered as a regular medication to reduce acute manic symptoms. Haldol as needed was also ordered.

Dr… viewed him as a direct threat after meeting him the first time and asked that I take over as primary psychiatrist. I evaluated [the recipient] on 10/17/15 and agreed with Dr… findings that he was in the midst of a manic episode. As my interview progressed he insisted on

leaving the hospital so he could field phone calls from other patients in crisis and my preventing him from leaving the hospital made me a 'murderer.' He repeated this multiple times as I left the unit. He was also asked to consider the threatening nature of his internet posts and the impression that his peers at school viewed him as a direct threat to their safety. He relatedly stated, 'that's perfectly fine' showing no remorse for these actions. [The recipient] received an as needed dose of Haldol on 10/19/15 after causing a disturbance on the 5 South Unit by intruding on several peers' personal space and eventually getting pushed and hit. He was seen to be calmer after the PRN was given but went on later to relate that he experienced unwitnessed fecal incontinence. He was also encouraged to take Truvada a prophylactic antiviral medication to address [the recipient's] exposure to unprotected sex with an individual with HIV prior to admission. Despite educating, he refused this medication from 10/15-10/19 resuming it on 10/20 and for the remainder of his stay. He continued to refuse psychotropics after an initial period of compliance on 10/19-10/20. He was feeling the medication to be making him feel odd. He was advised to keep trying the medication and that frequently when trying a new medication side effects occur which do go away. He ignored this advice and refused the medication from then on. This furthered our position that he was not competent to decide on medications. All psychotropic medications were withheld other then as needed medications which were not required. Much later in his stay he related feeling dizzy and weak since the try on medications which was never observed on the unit. He did request access to a homeopathic medication Melatonin 3mg to assist with sleep. The order was made but he stopped use of it also on 10/20.

[The recipient] for the next several days exhibited manic behavior; he consistently paced, spoke loudly and pressured. He consistently had a reason why he acted in these ways. He related he was 'intelligent and intelligent people speak pressured.' He also compared himself to Einstein and Beethoven in intelligence. He also provoked developmentally disabled patients telling them not to take their meds and telling one individual that staff had a crush on them. He referred to [a nurse] seeing him during his stay as 'an ant to him.'

Court papers were filed to get an involuntary medication order for Haldol long lasting injection or Risperdal Consta. [The recipient] persisted in calling the Associate Dean of Students at [his university] threatening lawsuits for their role in his admission to the hospital. He was phone restricted. What ensued were multiple weeks of similar behaviors including intimidation of staff by invading their personal space, advising peers that staff were incompetent and not to take their medications and referential thinking with [the recipient] advising me and other providers that we were having bad days. [The recipient's] advocate attempted to outreach me as did an expert doctor, Dr… regarding ways to work out his treatment without going through the courts. My assessment was that [the recipient] was highly manipulative and at high risk of relapse into acute symptoms and finally a court hearing was held in December to gain a court order for long acting Risperdal.

The court order was obtained 12/09/15 and oral Risperdal was ordered orally 2 mg nightly at bedtime starting that night. He did comply but was found to have red splotchy skin. Dr…, a dermatologist at Methodist Hospital, recommended the long acting injection be held until 12/18/15 to see if more of an allergic reaction developed. No allergic reaction developed so Risperdal Consta injection 25 mg was given on 12/18/15 and in the interim period while I was on vacation, [the recipient] showed a great deal of improvement. He did not develop more of a rash,

was not sedated or dizzy, and had no tremors. He did eat more than expected for the first week and was sleeping a lot up to 12 hours a night.

Since then he received his second injection 1/02/16. He has developed much more insight to his initial symptoms and behavior as being destructive and recognizes without his medication he says very grandiose and unrealistic. His speech is noticeably more goal focused and more understandable in rate. He has lost his grandiose tone. He is not displaying any depression or desire to harm himself or others. He now agrees the injection helps him and he would like to continue on it. He exhibits no psychotic or referential speech or thought……"

HOSPITAL REPRESENTATIVE RESPONSE

Hospital representatives were interviewed regarding the complaints. Staff discussed the restriction of the recipient's phone rights and it was pointed out that the record thoroughly demonstrates that the recipient made repeated threatening and harassing phone calls to the dean's office of his university. Staff also indicated that the recipient was a physically threatening presence throughout his hospitalization, however he was never administered forced emergency medication but rather accepted all PRN medication as is documented in the clinical record. The staff were also asked about the recipient's consent for medication and they indicated that the recipient consented to all medication, however he often refused his scheduled medication and he requested another medication which was contraindicated for his diagnosis. Near the end of the recipient's hospitalization he became compliant with his medication and began to show improvement overall as evidenced by his securing employment and being reconsidered for acceptance back into his university. Additionally, since the recipient's hospitalization the hospital revised the consent for medication form and there is now a form for medications which are consented to at admission and a separate form for medications which are started after admission.

Hospital representatives were interviewed about the description by the physician of an attack of the recipient by another patient on the unit and they were asked if this incident was investigated. They provided the following clarification:

"1. [The recipient] was never hit. There was one day in a group therapy session on Unit 5 South early in his hospitalization when [the recipient] was being verbally aggressive and not respecting the physical boundary of another patient in the group which resulted in this patient extending his arm to push [the recipient] out of their personal space. The push away by the patient had no potential for injury, and the situation did not escalate from there because the staff immediately addressed the issue by sending [the recipient] back to Unit 5B.

2. The staff does not recall the exact date of this group therapy session but this type of interaction among psychiatric patients is not uncommon, gave the staff no cause of concern because it was immediately addressed and pacified, and this minor physical touching did not rise to the level of an event that would warrant an incident report. An incident is generated for this the type of occurrence in the event there is a potential for injury, or if it escalates beyond what would be considered an expected type of interaction among psychiatric patients- and it did not.

3. On 10/15/15 [the recipient] was transferred from 5B to 5South because he was exhibiting increased agitation and unpredictability and the staff (and the recipient) agreed it would be best to remove him from that particular milieu.

4. On 10/16/15 [the recipient] complained to the APN [Advance Practice Nurse] about the threat of physical violence for being gay and [the APN] requested the unit staff to take this seriously and investigate. The staff did, however there was nothing to corroborate this statement he made to [the APN] so no additional documentation was generated. [The APN] did discuss a move back to 5B to avoid any potential for altercation but it was decided that there was no need for the transfer back on this date as he had just been removed from 5B for a similar reason.

5. On 10/19/15 [the recipient] was observed in verbal altercations with several patients, was extremely irritable, intrusive, poor boundaries, wandering into patients' rooms, screaming at staff and patients and demanding that he is in control and people need to listen to him. This aggressive and agitated behavior was not uncommon for [the recipient] but this particular day he was more relentless than? which resulted in him receiving a PRN of Haldol. He was also transferred back to Unit 5B.

6. On 10/21/15 [the recipient] was again getting into the face of other patients, was being manipulative and telling one patient that another had specific plans to hurt them. Again, not unusual for him and the staff managed it such that it never rose to the level of physical altercation."

Staff indicated that the physician did not see the recipient on the day (10/19/15) of the altercation he described in his report and did not ever observe an event where the recipient was pushed or hit. The physician explained that he prepared the report mostly from memory and from a review of the medical record. The physician was unable to confirm whether the statement was a mistaken note on his part or one of the stories that the recipient may have relayed during his sessions. Additionally staff indicated that there were no instances during the course of the recipient's hospitalization that were inconsistent with the usual and expected operation of the psychiatric units and his usual behavior during manic episodes.

With regard to the filing of a grievance, the staff indicated that anyone can complete a grievance at any time and any staff can provide the grievance form or the patient can write a complaint without any form at all. Additionally, there is also a complaint line that patients can call that does not require any written form and the number for this line is provided to all patients and posted by the phone. Staff further added that the recipient and his mother attended weekly treatment team meetings where grievances could have been shared, however the staff never received complaints or grievances from the recipient.

STATUTES

The Mental Health Code guarantees all recipients adequate and humane care in the least restrictive environment, pursuant to an individual services 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 (405 ILCS 5/2-102 a). Additionally, the Mental Health Code states that every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect (5/2-112). Also, the Code requires that the facility director of each service provider shall adopt in writing such policies and

procedures as necessary to implement the rights of recipients. Such policies and procedures may be amplified or expanded but cannot restrict or limit the rights guaranteed to recipients under the Mental health Code (5/2-202).

The Mental Health Code describes the requirements for the administration of psychotropic medication and its refusal:

"An adult recipient of services...must be informed of the recipient's 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. 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" (5/2-107).

"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 communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. .... 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 [to prevent harm]...." (5/2-102 a-5).

The Mental Health Code mandates that recipients shall be permitted unimpeded, private and uncensored communications with persons of their choice by mail, telephone and visitation. Correspondence must be conveniently received and mailed and reasonable times and places for the use of telephones and for visits may be established by the facility. Communication may be reasonably restricted only in order to protect the recipient or others from harm, harassment or intimidation. When communication is restricted, the recipient must be advised that he has the right to require the facility to notify the affected parties of the restriction and when the restriction is no longer in effect (5/2-103).

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 (5/2-201).

The Mental Health Code outlines the hospital response to allegations of a resident being the perpetrator of abuse. It states, "When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility." (5/3-211).

HOSPITAL POLICY

Methodist Hospital provided their policy regarding patients' rights (No. 1B-45). Among many other rights, this policy includes:

"… a. Patient has the right to participate in the development and implementation of his or her care.

b. The patient or his or her representative has the right to make informed decisions regarding his or her care, be informed of his or her health status, be involved in care planning and treatment, and be able to request or refuse treatment. This right must not be construed as a mechanism to demand provision of treatment or services deemed medically unnecessary or inappropriate…

f. The right to receive care in a safe setting.

g. The right to be free from all forms of abuse or harassment…

u. The patient has the right to be informed of hospital policies and practices that relate to patient care and treatment. The patient has the right to be informed of available resources for resolving disputes, complaints, grievances and conflicts, such as ethics committee, patient representatives, or other mechanisms available in the institution. A patient should request his/her nurse to notify the nursing supervisor for assistance. The supervisor is available 24 hours a day 7 days a week.

v. The patient (or support person, where appropriate), has a right to be informed of his/her visitation rights, including any clinical restriction or limitation on such rights, when he/she is informed of rights under this section.

w. The patient (or support person where appropriate), has the right, subject to his/her consent, to receive the visitors whom he/she designates, including but not limited to a spouse, a domestic partner (including same sex domestic partner), another family member, or friend, and his/her right to withdraw or deny such consent at any time. …"

Additionally, the policy states, "The exercise of Patient Rights provides for the impartial access to treatment, regardless of race, relation, sex, sexual orientation, ethnicity, age or handicap.

Regarding patient concerns, the policy states, "If the patient has a concern, they will be directed to contact the Nursing Supervisor for assistance. If the patient is not satisfied with the response, a written appeal may be filed through the hospital grievance process. At the completion of the appeal review, a written response will be forwarded to the complainant."

CONCLUSION

The clinical record for this recipient provides adequate justification for the restriction of his phone rights. Additionally, there is no indication that the recipient received forced emergency medication and his right to refuse medication was honored by the hospital numerous times. Also, the record shows written consent from the recipient for all medications. The record is less clear about an incident where the recipient was pushed or hit by another patient and whether or not this incident was investigated by staff. The HRA is hesitant to ignore the report of the physician to a mental health judge, however we accept the testimony of staff who were present at the time and we feel that due to the very professional documentation in the clinical record the recipient was given the careful attention of the treatment team and that they investigated each event thoroughly. Also, the HRA finds that the hospital provided numerous avenues for the filing of a grievance. The HRA does not substantiate the complaint that the facility did not follow Code requirements when it restricted a recipient's phone rights without

adequate reason, administered forced emergency medication without adequate reason, did not obtain the recipient’s consent for medication, did not investigate the attack of the recipient by other patients on the unit, and prevented the recipient from filing a grievance.