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North Suburban Human Rights Authority
Report of Findings
Chicago Behavioral Hospital
HRA #16-100-9018

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Chicago Behavioral Hospital. In July 2016, the HRA notified Chicago Behavioral Hospital of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation are as follows:

1. An adult patient did not receive copies of the admitting petition or certificates.
2. The unit was on lockdown due to suspected contraband; staff members "tossed" the room and the patient was made to go into the bathroom, remove all of his clothing, and bend over, squat and cough.
3. The patient experienced a medication error; he requested Effexor but was given Tylenol.
4. The patient's discharge was unjustly delayed because the Physician mistakenly noted that the patient made a threat, when in fact it was the patient's roommate that made the threat.
5. There was no soap in the bathroom.
6. Staff members jokingly told the patients that if they are non-compliant, they will get a shot of "booty juice" or be placed in seclusion or moved to another unit.
7. Staff members did not maintain patient confidentiality in that they discussed patient care in common areas.
8. The Dietary Department was unable to accommodate individual dietary needs.
9. The unit offered no structured therapies.
10. Telephone calls take place in the hallway that does not allow for privacy.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-103), the Illinois Confidentially Act (740 ILCS 110/), the Medical Patient Rights Act (410 ILCS 50/3) and the Illinois Administrative Code (77 Ill. Admin.Code 250).

To pursue this investigation, a site visit was conducted at which time the allegations were discussed with hospital personnel. The HRA reviewed the patient's clinical record with written consent. Also reviewed were hospital policy and practice.

Background

According to its web-site, Chicago Behavioral Hospital provides specialized mental health and substance abuse treatment. The hospital offers specialized programs to decrease symptoms of mental illness in inpatient and outpatient settings. The 125-bed hospital serves children, adolescents, adults and senior adults in the following inpatient programs:

The Extra Mile Veteran Care program provides services for those with Post-traumatic Stress Disorder (PTSD) and/or substance dependence.

The Women's Program offers treatment for depression, postpartum depression, depression during pregnancy, suicidal thoughts, homicidal thoughts, bipolar disorder, anxiety attacks, post-traumatic stress disorder and trauma from physical, emotional or psychological abuse.

The Geriatric Psychiatry Program addresses those struggling with one these symptoms along with dementia or Alzheimer's Disease: depression, bipolar disorder, bizarre behavior, suicidal thoughts or gestures, hallucinations, and extreme delusional thinking.

The Adult Mental Health program provides stabilization and treatment for adults with symptoms for: suicidal thoughts or behaviors, homicidal thoughts or behaviors, hopelessness, depression, anxiety, PTSD, Bipolar disorder, Schizophrenia, hearing voices, seeing things that are not really there, and extreme anger.

The Addiction Program offers a detox treatment for those with a co-occurring mental illness, like depression and bipolar disorder. This program is offered for ages 18 and older.

The Adolescent Mental Health program addresses: attempted suicide, skipping school, isolating him or herself, self-injuring, angry and does not know why, feeling hopeless, tried to hurt someone else, overly critical of him or herself, feeling overwhelmed frequently, experiencing bullying regularly, bullying others regularly, hyperactive all the time, unable to sleep, unable to pay attention, experimenting with tobacco, using marijuana or other drugs, such as speed or ecstasy, running away often and for long periods of time.

Allegation #1: An adult patient did not receive copies of the admitting petition or certificates.

Findings

The clinical record revealed data on a male patient admitted with the diagnosis of depression and anxiety. He was admitted on March 29, 2016 and discharged April 7, 2016. The chart contained a Pre-Registration form documenting that the referral source was a nearby hospital after the patient presented with increased suicidal thoughts and possibly homicidal thoughts. The chart showed that the patient was admitted to Chicago Behavioral Health Hospital at about 7:40 a.m. The chart contained a signed voluntary application; a time is not required on this document. It is noted that all Intake documents signed by the patient that did show a time were 8:41 a.m.

At the site visit, it was stated that all patients receive copies of the admission documents. If a patient presented to the hospital on a petition from a transferring site and then signed the voluntary admission, the petition would not be given to the patient.

Policy

The hospital's policy for Admission of Patient To The Unit states (in part) that patients' rights are given to the patient by the Intake Coordinator and any assistance needed to understand these rights are made available.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 3-205," Within 12 hours after the admission of a person to a mental health facility under Article VI or Article VII of this Chapter the facility director shall give the person a copy of the petition and a clear and concise written statement explaining the person's legal status and his right to counsel and to a court hearing. Following admission, any changes in the person's legal status shall be fully explained to him. When an explanation required by this Chapter must be given in a language other than English or through the use of sign language, it shall be given within a reasonable time before any hearing is held."
Section 3-611 of the Code states that, "Within 24 hours, excluding Saturdays, Sundays and holidays, after the respondent's admission under this Article, the facility director of the facility shall file 2 copies of the petition, the first

certificate, and proof of service of the petition and statement of rights upon the respondent with the court in the county in which the facility is located. Upon completion of the second certificate, the facility director shall promptly file it with the court and provide a copy to the respondent."

The patient was not admitted to this hospital on a petition; thus the allegation is unsubstantiated.

The HRA takes this opportunity to say that if a patient's hospitalization began with a petition from a transferring facility, a copy of the petition should be made available to the patient upon request which is their right under the Confidentiality Act.

Allegation #2: The unit was on lockdown due to suspected contraband; staff members "tossed" the room and the patient was made to go into the bathroom remove all of his clothing, bend over, squat and cough.

Findings

The record contained a Physician's order and a Notice Regarding Restricted Rights of Individual that noted the patient was subject to a body and belongings check for the "safety of patients and staff; to avoid contraband." There was nothing further in the chart regarding this restriction.

At the site visit it was stated that during visitation, staff members observed the patient's wife give the patient a few items. It was stated that due to the safety of the patient and others, staff members had to check the unit and the patient to see what had been passed. They found chap-stick and an antacid. It was stated that the room was checked and when body checks are completed the patient is asked to disrobe and squat. When this search is conducted, the mandatory two staff members are of the same gender as the patient. When asked, it was stated that body cavities are never checked; should this procedure be necessary, the patient would be sent to a nearby medical facility.

Policy

The hospital's Unclothed Body Search/Property Search policy states that personal possessions will be searched on admission and as clinically indicated to insure a safe environment for all patients. An unclothed body search will be conducted as clinically indicated to insure a safe environment for all patients. At all times staff must protect the privacy and dignity of the patient during the search procedure. The policy goes on to state that body orifices will not be searched by unauthorized personnel and that only physicians may perform body orifice searches. A room search for contraband may be executed according to unit guidelines and physician directive for cause.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, " (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 unit was placed on a lockdown due to suspected contraband; we have no evidence to prove the claim that staff members "tossed" the patient's room. The patient was in fact made to go into the bathroom remove his clothing, bend over and squat because of suspected contraband. This was done to maintain the safety of the patient and others; it is concluded that patient's rights were not violated.

The HRA takes this opportunity to suggest that events such as this be documented in progress notes, noting the staff that conducted the search and how the patient reacted to the process.

The HRA does not support the requirement that a patient must squat during a search, as it does not maintain the dignity of the patient. It is suggested that the facility revisit this requirement.

Allegation #3: The patient experienced a medication error; he requested Effexor but was given Tylenol.

Findings

According to the clinical record, the patient had an order for the Effexor (twice a day) and he had an order for Tylenol (as needed). The Medication Administration Records showed that he received both the Tylenol and Effexor as prescribed. There is a progress note that documented that an Effexor was found on the floor. When the patient was questioned, he denied it was his; it was documented that no other patient had been prescribed this medication.

At the site visit, it was stated that this allegation had been bought to the attention of hospital personnel while the patient was still receiving services. It was stated that an internal investigation was completed by reviewing a video of the medication area. Staff members offered that the video clearly showed that the patient was given the correct medication. The nurse interviewed stated that each medication is individually packaged in its own distinct packaging by color, type, and medication identification. The nurse stated that it would be almost impossible to confuse the two medications.

Conclusion

The Medical Patient Rights Act states, "The following rights are hereby established: (a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law." (410 ILCS 50/3 (a).

The HRA lacks substantiating evidence that the patient experienced a medication error.

Allegation #4: The patient's discharge was unjustly delayed because the Physician mistakenly noted that the patient made a threat, when in fact it was the patient's roommate that made the threat.

Findings

The chart contained an individual therapy note that documented that the therapist, psychiatrist and patient meet on March 31st (Thursday) regarding discharge. It was decided that the patient would leave that Saturday (April 2, 2016). On April 1st, it was documented that the patient had been appropriate and engaged in treatment, but he was agitated and angry due to a miscommunication between him and his psychiatrist. It was further documented that the patient's therapist was notified and talked to the patient. It was then noted that the patient was calm and cooperative. The chart did not show that the patient signed a 5-day notice of discharge.

At the site visit, the psychiatrist stated that he did not mistake the behavior of one patient for another. It was stated that after the decision had been made to discharge the patient on April 2nd, staff members obtained additional information that the patient had multiple guns at home. The psychiatrist stated that the discharge was delayed, to the 7th, due to unsafe conditions at home, and further offered that the patient received services three days past the insurance approval.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, "(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."

Based on the information obtained, nothing was found to support the claim that the patient's discharge was unjustly delayed; the allegation is unsubstantiated.

Allegation #5: There was no soap in the bathroom.

Findings

At the site visit, the HRA toured the unit and found the bathrooms have soap dispensers at the sink. When the patient showers, she/he is given a container of shower soap. We looked at the supply closet and observed that it was stocked with an assortment of hygiene products, including soap. In this room it was noted that patients have individual bins to store their products. Hospital staff stated that they had not had any complaints about soap not being available and that when a patient needs any hygiene product, they simple request it from a staff member.

Conclusion

Pursuant to the Illinois Administrative Code, Section 250.1040 "e) Room furnishings shall be arranged to facilitate nursing care and to avoid the transmission of infection."

At the time of the visit, the facility had an adequate supply of soap; it is concluded that patient rights are protected.

Allegation #6: Staff members jokingly told the patients that if they are non-compliant, they will get a shot of "booty juice" or be placed in seclusion or moved to another unit.

Findings

At the site visit, the nurse interviewed seemed surprised and somewhat appalled regarding the medication terminology. She adamantly denied that staff would say this to a patient. It was further offered that staff members do not joke about being placed in seclusion or being moved to another unit.

Policy

The hospital's Employee Conduct policy states that it is the policy of CBH to provide efficient and professional service to all patients, visitors, and co-workers.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, " (a) A recipient of services shall be provided with adequate and humane care and services…" The HRA lacks substantiating evidence that staff members jokingly told the patients that if they are non-compliant, they will get a shot of "botty juice" or be placed in seclusion or moved to another unit.

Allegation #7: Staff members did not maintain patient confidentiality in that they discussed patient care in common areas.

Findings

At the site visit, hospital personnel stated that patient care might be discussed while staff members are at the nurses' station. They do ask that patients stay clear of nurses' station and the hallway to maintain confidentiality. Staff members interviewed were aware of the importance of confidentiality. When asked, it was stated that staff members receive training during orientation regarding the need for patient confidentiality.

Policy

The hospital's confidentiality policy states that staff are educated on the Confidentiality of Alcohol and Drug Abuse, Patient Records regulation, access to and use of protected health

information governed by the Health Insurance Portability and Accountability Act. The policy goes on to state that, in addition, staff will not discuss or divulge any information obtained at CBH except in appropriate settings for clinical purposes.

Conclusion

Pursuant to the Illinois Developmental Disabilities and Mental Health Confidentiality Act Section (a) "All records and communications shall be confidential and shall not be disclosed except as provided in this Act. Unless otherwise expressly provided for in this Act, records and communications made or created in the course of providing mental health or developmental disabilities services shall be protected from disclosure regardless of whether the records and communications are made or created in the course of a therapeutic relationship."

Nothing was found to support the claim that staff members discuss patient care in common areas thus breaching patient confidentiality; the allegation is unsubstantiated.

The HRA realizes that during the course of a busy day, staff members might inadvertently discuss patient care in a common area that could be overheard by others. We take this opportunity to remind staff members about the importance of maintaining confidentiality at all times.

Allegation: #8: The Dietary Department was unable to accommodate individual dietary needs.

Findings

The complaint noted that the dietary department was unable to accommodate gluten free diets. According to the patient's History and Physical document, he had no dietary restrictions. The chart contained a Dietary Communication Form that showed he was on a general, heart healthy diet; there were no food allergies/intolerances and no Ethnic dietary restrictions. The chart contained a Daily Progress form that noted vital signs, blood pressure, hygiene and meals. It was noted that the patient typically ate 100% of his meals, with just a few days that he consumed 80% or 90% of a meal.

At the site visit, it was stated that all patients receive a nutritional assessment at the time of admission. Should the patient need a special diet, the Dietary Department is able to accommodate special diets. The HRA was showed the facility's dining room that serves cafeteria/self-serve type meals. Should a patient require something special, the patient is given a premade tray with the appropriate diet.

Conclusion

Pursuant to the Illinois Administrative Code, Section 250.1640 "a) All diets shall be ordered by the patient's attending physician and/or a registered dietitian with the attending physician's confirmation. Diet orders shall be recorded in the patient's medical chart. b) All diet orders shall be sent to the dietetic service department in writing. Each diet order shall have sufficient pertinent information to enable the dietetic service to serve the diet as prescribed by the physician."

Based on the information obtained, there is nothing to show that the dietary department is unable to accommodate individual dietary needs; the allegation is unsubstantiated.

Allegation #9: The unit offered no structured therapies.

Findings

The HRA requested and reviewed the unit's weekly schedule. The scheduled day begins at 6:30 a.m. and ends at 9:30 p.m. Scheduled groups included: life skills, social skills, stress management, self-awareness, safety goals, process group, current events, coping skills, nutrition, healthy habits. Scheduled in each day are also phone times and relaxation times.

The patient's treatment plan identified that the patient needed to work on his risk for violence and self-directed or directed towards others and medication education. According to the plan, these goals would be met by providing the patient with individual and/or group counseling. A review of the patient's chart showed that he actively and appropriately participated in groups on a daily basis; he was often praised and encouraged for his positive behavior during groups. Staff members offered that each unit has structured activities and the patient is given a copy of the schedule. The patient is encouraged to attend as many groups available as possible.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-102, " (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 patient had a treatment plan that addressed his area of need; documentation showed that he participated in structured activities on a daily basis. The allegation that the unit offered no structured therapies is unsubstantiated.

Allegation #10: Telephone calls take place in the hallway that does not allow for privacy.

Findings

The HRA toured the unit and noted that the public telephones are located on either side of nurses' station. The phones are not encased with any privacy walls. A conference room is available for private conversations.

The hospital's Telephones policy states that patients shall have unrestricted access by telephone to their lawyers, the Guardianship & Advocacy Commission, parole or probation officers, government officials and DCFS of a state ward. Telephones are located on the unit for patient use. Patients may have confidential communication in the conference rooms.

Conclusion

Pursuant to the Illinois Mental Health and Developmental Disabilities Code, Section 2-103 "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation."

Telephone calls do take place in a hallway; given the location of the phones, it does not appear to provide much privacy. However, since the facility has measures in place to offer confidential communication in a conference room, it is concluded that rights are protected.

The HRA takes this opportunity to suggest that the facility look into installing privacy walls to provide some semblance of privacy.