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HUMAN RIGHTS AUTHORITY – CHICAGO REGION

REPORT 18-030-9014
HARTGROVE HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) reviewed the care and treatment provided to a minor in the inpatient program at Hartgrove Hospital, a psychiatric facility in Chicago. The complaints under investigation were that:

1. The patient's parent was threatened with Department of Children and Family Services (DCFS)-removal of her son if she did not admit him.
2. The patient was allowed to sign his own preference for emergency intervention document.
3. The patient was prescribed Olanzapine doses that were inappropriate for his age and that caused severe side effects.
4. The patient was touched inappropriately by a peer.
5. The patient was not discharged within the mandated timeframe.

The rights of Hartgrove patients, their parents and guardians are protected by the Mental Health and Developmental Disabilities Code (405 ILCS 5). Substantiated findings of these complaints would constitute Code violations.

The Hartgrove Behavioral Health System provides a range of services including inpatient, outpatient and partial hospitalization to children, adolescents and adults. The HRA visited one location and discussed these complaints with administrators and those directly involved in the patient's care. Program policies were reviewed as was the medical record with authorization.

COMPLAINT SUMMARY

It was alleged that the seven-year-old patient was involved in a partial hospitalization program at Hartgrove when a psychiatrist became alarmed at the child's remarks about harming people, seeing knives at home and getting severe spankings. Staff reportedly called his mother

and told her to come sign him in for admission or they would call the DCFS and have him taken away, and she complied. During his stay, the patient was allowed to sign his own preference for emergency intervention document and he was prescribed Olanzapine, 5 mg, which, when he got home, caused him to be hot and sweat profusely. The parent checked with a pharmacist who reportedly told her the child was overmedicated. The complaint further states the parent signed a discharge request on October 1 and had to appear at the hospital to demand her son's release on October 6.

FINDINGS

1. The patient's parent was threatened with DCFS-removal of her son if she did not admit him.
5. The patient was not discharged within the mandated timeframe.

The patient's record contained an application by an adult for admission that was completed and signed by an emergency services counselor on September 22, 2017. The patient's mother signed the admission documents on September 24, and it was noted that the full list of discharge rights and advocacy contact information had been reviewed with the parent in detail. A rights of recipients form was reviewed and completed at the same time.

A "step-up" or clinical alert-related form to increase level of care accompanied the admission documents which noted the patient to have said to staff on the 22nd that he was going to jump out of a window or stab himself and that he heard commanding voices. A program manager who filled out the form described how the patient was talking to himself, responding to voices and stating ways to harm himself; he carried on and said that he knew where knives were and how easy it would be to use them. A note on the side of the form indicated that a psychiatrist would call the parent.

The attending psychiatrist's assessment report stated that she had reached the parent who said she would come in, but when was uncertain. The physician expressed her concerns about the child's hyperactivity, poor impulse control and attention as well as his suicidal thoughts and the voices. The parent shared her own concerns about recent troubles at school, and after discussing medication options, said she would come to the hospital. There was no indication of any contest in the discussion or mention of the DCFS at this point, and a targeted discharge date was set at September 29.

There were several physician and social work notes throughout the patient's stay that referenced their invites to the parent for visits or family sessions and her reluctance or inability to appear. Special hours and appointments were extended, and the parent agreed to hold a family counseling session by phone in one instance. A progress note on the 29th, the planned discharge date, described how the patient claimed to be abused by his mother. He told the psychiatrist that she would whip him pants down with an extension cord and said it really hurt—the DCFS was called, and discharge was delayed until the situation was cleared. Entries over the next days reflected Hartgrove's attempts to get word from the department without much success, and the parent and psychiatrist met on October 1 to discuss the matter. The parent

denied all accusations, and she was encouraged to sign a discharge request to help move things along. The form was signed then, clearance was received on October 6, and the patient was discharged home that day; exactly five days from the request.

The intake counselor who completed the admission forms was unavailable for the HRA's visit, so we spoke with another intake staff who was familiar with the case and what occurred at admission. She recalled how the parent was difficult to reach and that when she came in to sign the forms, she expressed her worries and wanted more intense treatment for her son. She said he was still having behavior problems and his voices were uncontrollable even after being in the partial program. The staff said that at no time was the DCFS mentioned or used as a threat at the time of admission. She explained that sometimes DCFS contact is warranted but never as a threat and that the staff would initiate petitions under the right circumstances. A therapist and the psychiatrist verified their documented accounts of when the patient began to cry abuse and their duty to report. They said the discharge request form was offered to help assure the parent of their intentions and they tried to reach DCFS workers regularly until they got word that all was ok.

CONCLUSION

Hartgrove's admissions policy states that a minor may be admitted by application of a parent or guardian in compliance with the Mental Health Code. Parents and guardians are provided with related rights information and given copies of all admission forms. The only mention of DCFS contact within the policy, is for when a parent remains uninvolved in a patient's need for hospitalization. A parent or guardian may request a minor's discharge at which time psychiatric evaluation is underway and the patient is either discharged within five days or a petition and certificates are filed in court.

Under the Mental Health Code, any minor may be admitted upon application of a parent or guardian, if the facility finds the minor appropriate for hospitalization (405 ILCS 5/3-503). Whenever a parent or guardian requests the discharge of a minor under Section 3-503, the minor must be discharged at the earliest appropriate time, not to exceed five days, unless a petition for review and two certificates are court filed (405 ILCS 5/3-508).

There is no evidence in the record or by staff recollection of the parent even objecting to her son's hospitalization let alone being threatened with DCFS intervention. The department was reached only when the patient claimed abuse at home; the parent signed a request for discharge which was honored right within the mandated timeframe. A rights violation is not substantiated.

SUGGESTION

-Verbal parental consent for admission should be noted and staff-witnessed on admission forms.

2. The patient was allowed to sign his own preference for emergency intervention document.

The record included a de-escalation preference form that permits any patient to alert the staff to what helps them calm down during stressful and emergent situations. Among other options like "looking out the window", this patient selected medications as his first preference and restraints his last. He and a staff member signed the form, but there is no indication that his choices were relayed to his mother or that his preference for medication was noted on his treatment plan.

The staff said that they do in fact ask all patients, including children, for their preferences for help when emergencies arise. No one could say how or when this patient's preferences were shared with his parent.

Pursuant to the Code,

> *Upon commencement of services…the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication…under…Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker….* (405 ILCS 5/2-200 d).
>
> *The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.* (405 ILCS 5/2-102 a).

CONLUSION

The Code makes no stipulation on the age of a patient when establishing the right to designate preferences for emergency interventions. The complaint that this minor patient was allowed to do so is not a potential rights violation. The Code does stipulate however, that a patient's designation shall be communicated to any guardian or substitute decision maker and noted in his or her treatment plan, neither of which were done in this case, at least by documentation. A violation of his full protected right on the subject is substantiated.

RECOMMENDATIONS

-Remind staff to always communicate stated emergency intervention preferences to guardians and substitute decision makers and add a check box to verify completion on the de-escalation form. (405 ILCS 5/2-200 d).

-Add emergency intervention preferences to all treatment plans. (405 ILCS 5/2-102 a).

3. The patient was prescribed Olanzapine doses that were inappropriate for his age and that caused severe side effects.

The record showed that Zyprexa (Olanzapine), 2.5mg at bedtime, was ordered on September 23, the day after this patient's admission. Discharge orders upped the dose to 5mg. Parental consent was obtained by phone on the 23rd according to the chart, and written drug information was shared with the patient the day after it was started. There is no indication whether the same written information was forwarded to the parent. There were also no psychiatry entries that referenced side effect trouble with Zyprexa.

The psychiatrist explained to the HRA that her patient was having troubles sleeping and that the doses she prescribed were "pretty low". Asked about side effects, she said he displayed none, and certainly nothing like profuse sweating. She said he had no complaints although he was a little tired in the mornings. Regarding informed consent, the staff said they always cover medication risks, benefits, side effects and alternatives with patients and guardians, by phone when parents are not present, but they were unsure of whether written drug information reached this parent.

CONCLUSION

Hartgrove policy states that a parent or guardian will provide informed consent for minors. Under necessary conditions for informed consent: "1. The patient (or parent or guardian) has the capacity to give an informed consent. The attending Psychiatrist may determine if a patient has the decisional capacity necessary to provide informed consent." The policy also outlines steps for obtaining treatment consent from absent parents, but nowhere does it ensure that written drug information is provided or sent to them.

The Code meanwhile, calls for written drug information to be provided to patients before treatment is started and the same written drug information to be given to their substitute decision makers (405 ILCS 5/2-102 a-5).

The HRA cannot say whether the patient was overmedicated or whether he experienced resulting side effects and defers to the prescriber who said she was not concerned. But, in order to be adequately informed, the parent has to receive written information about the drug she ultimately questioned and there is no documented evidence of that being done, only that the young patient was adequately informed. A violation of the Code's informed consent process is substantiated.

RECOMMENDATION

-Require appropriate staff to forward written drug information to absent parents or guardians and document completion in the record.

SUGGESTION

-Hartgrove's informed consent policy states that the attending psychiatrist *may* determine if a patient has the decisional capacity to provide consent. The Mental Health Code states meanwhile that the physician *shall* determine and state in writing whether the patient has decisional capacity. The HRA suggests that the policy wording be revised to reflect the Code's intention to always determine and document decisional capacity for adult patients.

4. The patient was touched inappropriately by a peer.

There was nothing in the record to suggest such an incident as alleged, including no similar reports or complaints from the patient or his mother. The HRA asked every staff present at our visit, individually, if he or she was aware of such a complaint at any time, from the patient, his mother or anyone else, and each answered no. They explained that if this incident had occurred, they would start an investigation by the patient advocate, call the respective parents, separate alleged victims and violators and conduct thorough evaluations of each. The appropriate authorities would be contacted with any significant findings.

CONCLUSION

The Code requires each patient to receive adequate and humane care and for peer on peer abuse to be thoroughly investigated, with evaluation for the facility appropriateness of any perpetrator (405 ILCS 5/2-102 a; 5/3-211).

For lack of evidence, the complaint is unsubstantiated.