FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Chicago Behavioral Hospital
HRA #18-100-9017

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 May 2018, the HRA notified Chicago Behavioral Hospital of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation alleged that medication was ordered without the patient being advised of the side effects and the risks/benefits of the medication. It was further alleged that a Physician breached confidentiality by discussing patient care in a community area.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/3).

To pursue this investigation, the HRA requested a copy of the patient's record, with written consent; the chart was obtained in July 2018. After review of the chart, a site visit was conducted at which time the allegations were discussed with the patient's Physician.

Background

According to its web-site, Chicago Behavioral Hospital, located in Des Plaines, provides specialized mental health and substance abuse treatment. The 125-bed hospital serves children, adolescents, adults and senior adults in both inpatient and outpatient programs.

Findings

It was reported that during the initial intake, the patient told the staff member of the two daily medications he takes for medical reasons. The day after admission, he was presented with three medications and when he asked what the third medication was, he was told an anti-depressant. He told the Nurse that he had not met with a Physician regarding this medication and he knew nothing about it. The Nurse returned with written information, but the patient stated he refused to take it and the refusal was honored. It was reported that the patient met with the Physician on the 4th day of the hospitalization and the Physician questioned why he had not been taking the medication. The patient replied that the Physician knew nothing about him as it was the first time they had met so how could he prescribe a medication. The Physician replied that he had read the chart and knew what to order. It was further reported that the Physician also breached confidentiality by discussing patient care in the dayroom.

The clinical record revealed data on an adult male voluntarily admitted to the hospital on February 5, 2018, due to increased depression with suicidal ideation. He was discharged on

February 12, 2018. The Psychiatrist documented in the initial psychiatric evaluation, dated February 5, 2018 at 7:00 p.m., that the patient was accepting of direction and he should be compliant with treatment recommendations. The patient was able to express his feelings verbally, he acknowledged that he needs treatment and that he has family support. The evaluation documented that the medication plan was to continue with the current treatment and medications. It was documented that the medication potential risks, benefits and side effects were discussed with the patient and the patient understood and agreed to proceed.

The chart showed that the medication Lexapro (an antidepressant) was ordered on February 5, 2018 at about 9:30 p.m. On the 7th, the patient refused the medication, saying that he needed to first talk to the Physician before he takes that medication. All subsequent refusals were honored. The chart contained a Psychotropic Medication Notice and Consent Form which contained a paragraph stating that the Physician/designee and the patient discussed the following*: "1. The nature of my condition; 2. My physician's reasons for prescribing the medication, including the likelihood of my condition improving or not improving without the medication; 3. I can refuse to not take any medication at any time, but it is recommended that I discuss my decision with my physician before I stop taking any medication; 4. Reasonable alternative treatments available for my condition; 5. The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication and the duration of such treatment; 6. The common side effects of the medication, and any particular side effects likely to affect me, risks and benefits; 7. That certain antipsychotic medications may cause additional side effects for some persons, including tardive dyskinesia."* The consent was only for the Lexapro, which the patient did not sign, documenting on the form, "I don't take it". The chart contained a Patient Education Record form indicating that medication teachings were provided to the patient for the Lexapro and Coumadin (a blood thinner).

The Psychiatrist wrote on the 7th that the patient was refusing the Lexapro and noted that the patient was anxious, restless, irritable and discharged focused. The next two days and again on the 11th, it is noted in Psychiatrist progress notes that the patient is refusing the Lexapro.

In discussing the allegation with the Physician, he stated that all patients must be examined within 24 hours of admission. It is at that time that medication options would be discussed and the patient would then agree or disagree with the proposed treatment options. The Physician explained that PRN (as needed) medications can be ordered before the patient is seen, but these medications are only to be used on an emergency basis. The Physician did not recall the patient identified in the allegation.

The Physician stated that patient care is not discussed in public areas. Sometimes a patient will approach him when he is on the unit, and he will need to remind the patient that he cannot discuss treatment out in the open, and they will then go to therapy room or group room. When discussing patient care with nurses, he stated there is a room off the nurse's station that is used for conversations.

The HRA interviewed two patients that were receiving services. One patient stated that she did not know what medications she had been prescribed. She then went on to identify each medication by name that she had taken and/or requested during her hospitalization, in addition to medications that she thought might be of benefit to her and how they would help. When asked if she had ever heard a Physician talk about another patient in a public area, she replied by saying, you mean a HIPAA violation - she stated that it happens. The second patient stated that she had consented to the prescribed medication and knew what it was for; she expressed a desire to be on

additional medications. She did not recall overhearing confidential information being discussed in public areas.

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." Section 2-102 (a-5) states that, "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."

Pursuant to the Illinois Mental Health and Developmental Disabilities Confidentially Act, Section 3 (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."

The Physician stated that within 24 hours, all new patients are examined and recommended medication would be discussed at this time. The chart contained a consent form that described what the Physician/designee and the patient discussed regarding the medication, and the patient signed the form indicating he did not want the medication. However, nothing was found to indicate that the recipient had the capacity to make a reasonable decision about his treatment. The patient stated that a Nurse had given him written information about the risks and benefits of the medication. However, the written information should have been provided before the treatment was offered. The allegation that medication was ordered without the patient being advised of the side effects and the risks/benefits of the medication is substantiated.

Based on the information obtained, nothing was found to support the allegation that a physician breached confidentiality by discussing patient care in a community area.

Recommendations:

The hospital must ensure that: 1) the physician states in writing whether the recipient has the capacity to make a reasonable decision about the treatment. 2) the physician or the physician's designee must provide the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, before the treatment is offered; documentation should indicate the same.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

CHICAGO
BEHAVIORAL HOSPITAL

December 7, 2018

Patricia Getchell, Chairperson
North Suburban Regional Human Rights Authority
9511 Harrison Avenue W-335
Des Plaines, IL 60016-1565

RE: HRA#18-100-9017

Ms. Getchell:
Chicago Behavioral Hospital takes this opportunity to respond to findings from allegation HRA#18-100-9017, which were received to us on November 10, 2018. We sincerely appreciate the professionalism and courtesy of the investigators throughout the process, and recognize the importance of the collaborative efforts of IDHR and our hospital in order to provide the most humane, ethical, and clinically appropriate care for all of the patients that we serve.

In response to the substantiated allegation that medication was ordered without the patient being advised of the side effects and the risk/benefits of the medication, we take this opportunity to make comment on that finding, as well as provide the Authority with our corrective actions to ensure that patient rights continue to be upheld in our facility. We do not believe that this patient was inadequately provided with informed consent, based off of the results of this investigation. We also feel that there was adequate documentation in the Physician's Psychiatric Evaluation and Daily Progress Notes, which both do mental status examinations to show that the patient was capable of making decisions on his own behalf. Although we do not necessarily feel that these allegations are substantiated as they are written, we wholeheartedly agree that any ambiguity is a chance to use this as an educational opportunity for our staff members.

As a result of the findings, we will be proceeding with the recommendations of the Authority. Re-education has already begun with the Nursing Department Staff concerning "the physician or the physician's designee must provide the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, before the treatment is offered; documentation should indicate the same". Nursing staff will be provided re-education on providing written education to patients prior to the first dosage of psychotropic medications, and document in the patient's Educational Record.

Secondly, the physicians will be re-educated on December 18, 2018 on ensuring that the patient's capacity to make reasonable decisions on their own behalf is documented upon initial Psychiatric Evaluation, and any changes in level of cognitive functioning or capacity to make decisions is documented appropriately on Daily Progress Notes.

Again, we appreciate the efforts of the Authority to work with facilities in maintaining and enhancing policies and procedures which uphold the rights of the patients we serve. Please feel free to contact me with any further assistance you may require in this matter.

Sincerely,

Anthony King
Director of Performance Improvement
Chicago Behavioral Hospital
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