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REPORT OF FINDINGS
PROVENA SAINT JOSEPH MEDICAL CENTER — 09-040-9001
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—— The Authority found violations in one of the three complaints presented; the public record on this investigation is found below. The hospital's response is not included in the public record.

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission opened this investigation concerning Provena Saint Joseph Medical Center in August 2008. This general hospital located in Joliet has an adult and adolescent psychiatric unit with a 34-bed total capacity. The complaint alleged that the hospital staff: 1) did not follow the Code's admission process, 2) restrained and administered psychotropic medication without justification, and, 3) did not allow the recipient to participate in her treatment planning.

If substantiated, these allegations would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.).

METHODOLOGY

To pursue the investigation, the hospital's Counsel, the Risk Manager, the Director of Behavioral Health, the Manager of Patient Care, the Attending Psychiatrist, a Licensed Clinical Social Worker, a Licensed Social Worker and two Registered Nurses were interviewed. The allegations were discussed with the Risk Manager during closed sessions at the South Suburban Regional public meetings. The recipient's record was reviewed with consent. Relevant hospital policies were also reviewed.

The adult recipient maintains her legal rights.

COMPLAINT STATEMENT

According to the complaint, the recipient was taken to Provena Saint Joseph Medical Center's (PSMC) Emergency Department for a psychiatric evaluation; she refused to cooperate during the assessment process and was involuntarily admitted to the hospital's behavioral health unit. Once there, the recipient allegedly was not examined by a psychiatrist within the Code’s required timeframe and was restrained and administered psychotropic medications without

cause. Additionally, the recipient was said to not be allowed to participate in her treatment planning.

FINDINGS
Complaint # 1

The Emergency Department Record corroborated that the recipient was transported to the hospital for a psychiatric evaluation on Friday, June 27th, 2008. She arrived by ambulance at 4:18 p.m., and the police and the recipient's parents were with her at the hospital. She was triaged at 4:36 p.m., and the nurse wrote that the recipient had been disorderly in the community after being discharged by court-order from a local psychiatric inpatient unit on that same day. A petition was completed by the recipient's mother at 5:00 p.m. alleging that the recipient had discontinued taking her medications and that she was paranoid. According to the petition, the recipient had threatened her father with a knife and her fists. She reportedly had problems sleeping and had been walking for hours. She also had refused to eat because she believed that her food was poisoned.

The emergency room physician's report stated the recipient was alert and cooperative upon examination. Her mood was labile, and her affect was sometimes flat. Her insight and judgment were impaired. The recipient was reportedly delusional and paranoid but without suicidal or homicidal ideations. A Licensed Social Worker (LSW) documented that the recipient quickly deteriorated upon further examination and over time. She reportedly became verbally confrontational about legal issues when asked questions used to determine suicidal risk. She told the LSW that the court had this information in their records. The LSW completed the first certificate affirming by signature that rights were admonished prior to the examination on June 27th, 2008 at 5:10 p.m. According to the certificate, the recipient was paranoid, hypervigilant, delusional, and her speech was pressured. She reportedly believed that her parents had altered documents to take away her inheritance and that others were involved. The certificate asserted that the recipient needed immediate hospitalization because she was reasonably expected to engage in dangerous conduct.

Documentation indicated that the psychiatrist on-call agreed that inpatient care was needed. The recipient was admitted to the hospital's behavioral health unit on that same day, and she refused to cooperate with the nursing assessment per the documentation. A nurse wrote on the Rights of Individuals Receiving Mental Health and Developmental Disabilities Services form that the recipient refused to listen to or discuss her rights. The same nurse signed the petition affirming that the recipient was given a copy of the document on the admission day at 9:55 p.m. She also recorded that the recipient was given a copy of the certificate. The next day the psychiatrist documented that an initial evaluation was done. A second certificate was completed on June 28th, 2008 at 2:00 p.m., and the psychiatrist affirmed by signature that rights were admonished. The certificate stated that the recipient was paranoid, manicky, delusional, hostile and uncooperative. It asserted that the recipient was unable to care for herself.

The Psychiatric Evaluation Report dictated on June 29th, 2008 repeated that the recipient was extremely hostile and uncooperative during the interview. She asked the clinician if he was a psychiatrist and then replied "absolutely not". The recipient told the psychiatrist that she had

the right to refuse to talk to him and walked out of the room. The psychiatrist wrote that he was not able to get any psychiatric history, nor evaluate the recipient. The report documented the psychiatrist's clinical impressions of Bipolar Disorder, Most Recent Episode Hypomanic. The same day a psychiatry entry described the recipient as angry and irritable. She refused to answer questions or give consent to secure records from her last hospitalization. A History and Physical Report dictated on June 29th, 2008 indicated that the recipient was very hyperverbal and paranoid. She declined laboratory work, but she appeared to be in good health.

On June 30th, 2008, the unit's Licensed Clinical Social Worker (LCSW) recorded that the recipient refused to meet with her parents or give written consent for sharing information with them or sign a Voluntary Application. The record indicated that on the next day the recipient was given a copy of the notice regarding the court hearing for involuntary commitment scheduled for July 2nd, 2008. Although nursing documentation suggested that the recipient was informed about the outcome of the court hearing on the following day, there was no explanation regarding what the court had ordered. The hospital later provided a copy of the order indicating that the recipient's petition for discharge was granted on July 2nd. The next day nursing entries recorded that the recipient "continues to think she is going to be discharged to herself and she plans to take the train to her home." She maintained that there was nothing wrong with her and that she did not need hospitalization.

A July 3rd, 2008 psychiatrist's order indicated that plans were made to involuntarily transfer the recipient to a state operated mental health facility. The LCSW wrote that the receiving facility was familiar with the recipient and that her transfer must include a petition and a certificate. She also recorded that the facility would not be able to consider the transfer request until the week of July 7th, 2008. The record contained a second petition completed by the LCSW, and a third certificate prepared by the psychiatrist on July 3rd, 2008. The involuntary documents repeated information written on the first petition and the two certificates previously mentioned. They further alleged that the recipient was verbally aggressive toward peers and staff, she was constantly talking to herself at the front desk, her insight concerning her mental illness was poor, and she refused to take medication. The documents asserted that the recipient was reasonably expected to engage in dangerous conduct and that she was unable to provide for her basic physical needs without the assistance of family or outside help.

Psychiatry and nursing entries indicated that the recipient remained paranoid, delusional, hyperverbal, and irritable although a July 6th, 2008 psychiatry note stated that the recipient lacked suicidal or homicidal ideations. The next day the recipient attended a family meeting with her mother, the LCSW and the Manager of Nursing. The meeting note indicated that the recipient's mother was willing to assume responsibility for the individual, and she was discharged on that same day. A psychiatrist's note stated that the recipient refused to meet with him on the discharge day and declined follow up care and medication.

The recipient's involuntary admission to the hospital was discussed with Provena's staff. According to the emergency room's LSW, the recipient became more agitated as her rights were explained during the assessment process. She refused to answer questions pertaining to her safety. The psychiatrist explained that the recipient was extremely hostile during the first interview, and his clinical opinions were based on observations because she refused to talk to

him. She was reportedly psychotic during her hospital stay. She would talk to herself, and she exhibited hostility toward other recipients. She usually stayed in her room, but she came out for food. Her appetite and hygiene were good.

The July 2nd, 2008 court hearing for involuntary commitment was discussed. The HRA was informed that court hearings had previously been held in a conference room on the hospital's behavioral health unit. The Director of Behavioral Health, the physician, and the recipient always attended the hearings on the unit. All commitment hearings are now held at the court house, and the hospital does not have sufficient staff available to attend each hearing. A fax cover sheet from the court documented that the hospital received the July 2nd dismissal order on July 17th, 2008. According to Provena's Counsel, the hospital was not timely notified that the court had dismissed the involuntary documents on the hearing date. However, the Director of Behavioral Health said that the hospital failed to secure a copy of the order sooner because the hearing was held during the week of a holiday. The Manager of Patient Care further acknowledged that she was informed by an employee of the court about the dismissal order on July 2nd, and she told the nurse who shared information about the hearing outcome with the recipient. She also notified the recipient's psychiatrist who decided that the individual might benefit if she was transferred to the state facility that was familiar with her. The Manager of Patient Care reported that the recipient and her family were in agreement with the transfer plan.

According to the hospital administration, the following new procedures have been put in placed concerning court outcomes: 1) A designated court employee will notify the hospital by phone and a copy of the order will be faxed, and, 2) The recipient's attorney will also call the provider regarding the hearing disposition. The HRA was informed that the appropriate hospital's staff were trained on the new procedures from outside agencies in July 2008.

The second petition and third certificate completed on July 3rd, 2008 were discussed with the staff. According to the Manager of Patient Care, the recipient wanted to be transferred to a specific state operated facility because her physician was on staff there. The LCSW who prepared the second petition reported that the facility in question requires a petition. She also wrote in the record that the facility requested a petition accompanied by a certificate.

The hospital's "Mental Health/Involuntary Admission" policy states that when a recipient presents to the emergency area and is admitted to the mental health facility, a petition must be completed if the person refuses or is unable to sign a Voluntary Application. The policy states that a qualified examiner or physician shall complete a certificate. The qualified examiner who conducts the examination must inform the recipient of his/her rights prior to the evaluation. It also states that the Rights of the Patient are given on the mental health unit.

CONCLUSION

According to the following Sections of the Code,

> When a person is asserted to be subject to involuntary admission and in such a condition that immediate hospitalization is necessary for the protection of such person or others from physical harm, any

> person 18 years of age or older may present a petition to the facility director of a mental health facility in the county where the respondent resides or is present. The petition may be prepared by the facility director of the facility. (405 ILCS 5/3-601[a]).
>
> The petition shall include a detailed statement of the reason for the assertion that the recipient is subject to involuntary admission, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence. (405 ILCS 5/3-601[b]).
>
> The petition shall be accompanied by a certificate [and] … shall indicate that the physician, qualified examiner, or clinical psychologist personally examined the respondent not more than 72 hours prior to admission. It shall also contain the physician's…clinical observations, other factual information relied upon in reaching a diagnosis…. (405 ILCS 5/3-602).
>
> Whenever a petition has been executed …, and prior to this examination for the purpose of certification of a person 12 or over, the person conducting this examination shall inform the person being examined in a simple comprehensible manner of the purpose of the examination; that he does not have to talk to the examiner; and that any statement he makes may be disclosed at a court hearing on the issue of whether he is subject to involuntary admission…. (405 ILCS 5/3-208).
>
> Within 24 hours, excluding Saturdays, Sundays and holidays, after admission of a respondent under this Article, the respondent shall be examined by a psychiatrist. The respondent shall be released if the individual is not examined or a second certificate is completed. (405 ILCS 5/3-610).

In Illinois there is only one way to be detained involuntarily for psychiatric evaluation and that is via the Mental Health Code's process, under which a petition must be completed in order to start the involuntary process and have authority to hold any adult. The record illustrated that the recipient's hospital admission meets the following requirements of the Code. A petition was completed by the recipient's mother shortly after she arrived at the Emergency Department on June 27th, 2008 at 5:00 p.m. under Section 5/3-601 (a). The document included detailed information concerning the recipient's observed threats pursuant to Section 5/3-601 (b). The Code requires that a petition be accompanied by a certificate for immediate hospitalization. The first document was prepared by the hospital's social worker, who is a qualified examiner, at 5:10 p.m. on that same day under Section 5/3-602. The next day the recipient was examined by a psychiatrist who prepared a second certificate at 2:00 p.m., within the timeframe of Section 5/3-

610. Additionally, the social worker and the psychiatrist affirmed by their signatures that the recipient's evaluation rights were shared prior to examination under 5/3-208.

The HRA does not substantiate that the hospital staff did not follow the Code's admission process.

COMMENT

> If the respondent is not found subject to involuntary admission, the court shall dismiss the petition and order the respondent discharged. (405 ILCS 5/3-809).

The Authority is very concerned because the recipient should have been discharged on July 2nd, 2008 after having been found not subject to involuntary admission by a court. The order was reviewed during the investigation. The hospital's Counsel said that the provider was not timely informed about the court's decision, but nursing documentation indicated that information was shared with the recipient concerning the outcome on July 2nd. The Manager of Patient Care also acknowledged that she was informed by an employee of the court about the dismissal order on July 2nd. She reportedly shared this information with the nurse and the assigned psychiatrist. However, the recipient was not discharged until July 7th.

SUGGESTION

Follow the Code and ensure that recipients are promptly discharged when petitions are dismissed by the court per Section 5/3-809. Otherwise, be sure that their rights are protected under the Code's voluntary or informal admission routes.

<u>Complaint # 2</u>

The complaint alleged that the recipient was restrained and administered psychotropic medication without justification.

There was no written evidence that the recipient was given psychotropic medications or restrained in the emergency room. Documentation in the recipient's inpatient record indicated that Haldol, Ativan and general medications as needed were ordered at admission, but only signed consent for general treatment was found in the record. The recipient's parents told the LSW that the individual previously had a very bad reaction to Haldol, but the psychiatrist recorded that she was not allergic to the medication. The psychiatrist also wrote that more medication information should be obtained from her parents and her last hospitalization.

According to the June 29th, 2008 History and Physical Report, the recipient said that she usually does not take medications but her parents and others had previously forced her to take them. The next day the recipient's parents gave the LCSW a written history of the recipient's psychiatric treatment including medications when they presented for a visit. She refused to sign a release of information for the LCSW to talk to her parents. Her parents wrote that the recipient had done well on low dosages of Zyprexa, but she had severe side effects from Haldol.

According to Medication Administration Records (MARs), Haldol was discontinued on that same day, and the medication was never given.

Medication records furthered revealed that Ativan 2mg IM (intramuscular) was administered on July 1st, 2008. A nursing entry leading up to the medication stated the recipient was hostile, very delusional, and she became angrier when offered as needed medication. The recipient was reportedly not restrained, but she was cooperative with the injection. Zyprexa 20 mg orally at night was ordered on that same day. The psychiatrist recorded that the recipient's signed consent must be obtained prior to administering the medication, but the record lacked a clear decisional capacity statement or that written information regarding the proposed medications was given. According to the record, the recipient refused to give consent or accept Zyprexa when offered on the order day. The recipient stated, "I will take you to court tomorrow, the court will decide, now get out of my room" when the nurse approached her about the medication.

Nursing entries reflected that the recipient was pleasant on July 2nd, 2008 except for one incident with her roommate. According to MARs, the recipient refused medications on July 2nd and 3rd, and they were not given. The next day the recipient exhibited flight of ideas, but there was no indication whether medications were offered on this day. Documentation on July 5th, 2008 indicated that the recipient was verbally aggressive toward another recipient, and she was upsetting other recipients. The hospital's security was called because interventions to calm her were ineffective. Ativan 2 mg IM was administered, but the record lacked a restriction of rights notice. The nurse wrote that the recipient stopped screaming and slamming her room door after the medication was given. There was no evidence that medication was given after July 5th, 2008 or that restraints were used at any time.

At the site visit, the investigation team inquired about informed consent for psychotropic medication. On questioning, the psychiatrist acknowledged that he did not advise the recipient of the side effects, risks, benefits or alternatives to the medications. He also said that Zyprexa had been previously been prescribed. The HRA was informed that the hospital has revised its psychotropic medication consent form, and that recipients are provided with micromedex sheets or written medication sheets.

The nurse who administered Ativan on July 1st, 2008 stated that the medication was given under emergency circumstances because of agitation. Upon questioning, the nurse said that the recipient became very hostile and approached other recipients in a threatening manner. She also stated that the recipient did not refuse the medication. The nurse who administered Ativan on July 5th, 2008 said that the medication was given because the recipient was verbally and physically threatening toward others. She reportedly was in other recipients' personal spaces with a loud and intimidating voice. According to the nurse, she tried to calm the recipient before the hospital's security was called for assistance. The HRA was informed that the recipient did not refuse the medication and that recipients are asked about their emergency preferences. However, there was no written evidence to support the staffs' assertions or that she was asked about her emergency treatment preferences or restriction contacts.

Subsequent to site visit, the HRA was provided with a copy of the hospital's "Psychotropic Medication Consent" form that was reportedly revised after the recipient's hospital stay. The form includes a statement that the patient verbalizes an understanding and agrees to the treatment listed on the form.

According to Provena's "Patient's Bill of Rights and Responsibilities" statement #7, adequate and appropriate information will be provided for recipients' informed consent prior to the administration of non-emergent treatment.

The hospital's "Restriction of Patient Rights" Policy states that all patients admitted to the behavioral health unit shall maintain their rights in accordance to the Mental Health and Developmental Disabilities Code. A patient's rights may be restricted by a physician's order for therapeutic reasons. If restricted, a notice of the restriction will be given to the patient and a copy will be mailed to anyone of the individual's choice.

CONCLUSION

> 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 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]).
>
> 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 …. 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 5/2-107 …. (405 ILCS 5/2-102 [a-5]).
>
> 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 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…. (405 ILCS 5/2-107 [a]).

> Psychotropic medication or electroconvulsive therapy may be administered under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record. (405 ILCS 5/2-107 [b]).
>
> Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the right to designate, a person or agency to receive notice under Section 2-201 or to direct that no information about the recipient be disclosed to any person or agency. (405 ILCS 5/2-200[b]).
>
> Whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction. (405 ILCS 5/2-201).

Haldol and Ativan as needed and Zyprexa daily were ordered during the recipient's inpatient stay, but there was no evidence that informed consent was obtained beforehand. The recipient refused Haldol and Zyprexa, and they were not given over her objections. Medication records documented that Ativan IM was given twice. A nurse reported that emergency medication was administered because of threatening behavior on July 1st, but the record does not clearly support this. The same nurse wrote that the recipient was hostile and very delusional leading up to the medication. The nurse also said that the recipient did not refuse the first injection, although there is no clear documentation that she had the opportunity to refuse. Section 5/2-102 (a-5) requires informed consent for accepted medications, based upon written and verbal education and a physician's written statement of the recipient's capacity to make a reasoned decision when they are proposed, all of which was missing for the first dose that the recipient was said to not refuse.

Additionally, the hospital's "Psychotropic Medication Consent" form's statement that the patient verbalizes an understanding and agrees to the treatment listed on the form does not meet the decisional capacity requirement under Section 5/2-102 (a-5). That Section requires that the physician make a written determination of whether the person has the capacity to make a reasoned decision regarding the treatments versus the recipient saying that he understands the information shared.

Another nurse said that the second injection of Ativan was given because of verbal and physical threats toward others. The nurse documented that the hospital's security was called because the recipient was verbally aggressive toward another recipient and lesser interventions had failed. Although it was not clear whether the recipient's aggression included potential

physical threats, there was no evidence that her emergency treatment preferences were ascertained or that she was given the opportunity to refuse the second injection as required by Sections 5/2-102 (a) and 5/2-107 (a). The hospital's "Psychotropic Medication" policy mirrors Section 5/2-107. It also states that a restriction notice shall be completed if medication is given over the recipient's objections. The record lacked a restriction notice that would justify the intervention and provide the recipient rightful opportunity to have anyone of her choosing to be notified under Sections 5/2-200 (b) and 5/2-201.

The HRA substantiates violations of the Code, the hospital medication policy and patient Bill of Rights statement #7.

Based on the record, the Authority does not substantiate that the recipient was restrained.

RECOMMENDATIONS

1. Follow Code requirements and document whether a recipient has the capacity to give informed consent about proposed treatments, ensure that written drug information is provided, and ensure that informed consent is obtained before administering psychotropic medications under Section 5/2-102 (a-5).

2. Ensure that recipients are always given the opportunity to refuse medications pursuant to Section 5/2-107 (a).

3. Instruct staff to document emergency treatment preferences in individual treatment plans and ensure that preferences are always considered whenever emergencies arise as required under Section 5/2-102 (a).

4. Follow Code requirements and the hospital's policy regarding the issuing of restriction of right notices.

5. Follow Section 5/2-200 regarding rights admonishments.

6. Train or retrain all appropriate staff regarding the Code's treatment process regarding medication and capacity determinations.

7. Provide the HRA with documentation to verify the completion of staff training.

8. The hospital should revise its medication policy to clarify that a physician's written determination of whether a recipient has the capacity to make a reasoned decision about proposed treatment is required; understanding may be one element of having capacity but a clear statement must be documented in recipients' records to reach the standard.

<u>Complaint # 3</u>

Additionally, the complaint alleged that the hospital did not allow the recipient to participate in her treatment planning.

An HRA review of the treatment plan initiated upon the recipient's admission on June 27th, 2008 stated that she was paranoid and delusional. A nurse wrote on the treatment plan that the recipient refused to participate in the assessment process or sign the plan. On July 3rd, the same nurse recorded that the recipient continued to deny the need for hospitalization or medication. She also refused to sign a release to engage her family in her treatment, although she later agreed to having a family meeting.

The hospital's staff said that the admitting nurse is responsible for developing the treatment plan upon the recipient's arrival on the unit. The plan is based on the recipient's needs and reviewed with the individual. The clinical team reportedly meets every Monday to discuss cases, and the social worker then meets with the recipient and reviews the plan. According to the Director of Behavioral Health, the treatment plan was reviewed with the recipient, but she refused to sign the plan.

Provena's "Admission Forms" policy states that the nurse is responsible for completing the appropriate portion of the multidisciplinary assessment form. All staff making entries on the treatment plan must sign the plan.

According to the hospital's "Patient's Bill of Rights and Responsibilities" statement #21, patients have the right to be an active participant in the development and evaluation of their healthcare plans.

CONCLUSION

Section 5/2-102 (a) of the Code guarantees all recipients of services that adequate and humane care and services shall be provided, 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….

Based on supportive documentation, the Authority does not substantiate that the hospital did not allow the recipient to participate in her treatment planning. No violations of Section 5/2-102 (a) or the hospital's policy or patient's rights statement #21were found.

COMMENT

Although there was no evidence that the LCSW shared information with the recipient's parents, the HRA must caution the provider because her parents provided written psychiatric information

including medications that were used in the recipient's treatment plan without her consent. According to the record, the recipient did not want her parents involved in treatment planning prior to the family meeting. Her parents gave the written information to the LCSW before the recipient agreed to the discharge meeting.