FOR IMMEDIATE RELEASE

North Suburban Human Rights Authority
Report of Findings
Resurrection Westlake Community Hospital
HRA #09-100-9036

Case Summary: The HRA substantiated the allegations presented. The HRA's public record on this case is recorded below; the provider's response immediately follows the report.

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Westlake Community Hospital. In May 2009, the HRA notified Westlake of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaints accepted for investigation are that a consumer received forced medication without justification. It was further reported that when she refused the medication, she was automatically sent to her room where she received the injection. It was reported that the consumer would have liked to have been counseled and talked to prior to the administration of the medication and not just forcibly injected.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107) the Illinois Probate Act of 1975 (755 ILCS 45/4-1).

To pursue this investigation, a site visit was conducted at which time the allegations were discussed with the hospital's Vice President of Patient Care Services, the Director of Nursing, and the Manager of the adult program. The HRA reviewed, with written authority, the clinical record of the consumer whose rights were alleged to have been violated. Also reviewed were hospital policies relevant to the allegations.

Background

Westlake Hospital is a 282-bed facility located in Melrose Park. The hospital's Mental Health and Addiction services provide comprehensive care for children, adolescents, adults, and seniors in both inpatient and outpatient settings. The continuum of services includes: emergency/crisis care, a 25-bed inpatient treatment program, outpatient therapy, short- and long-term residential programs and home visits.

Findings

The record revealed data on a female consumer who admitted herself to the hospital on March 16, 2009. The hospitalization course was characterized by catatonia, non-verbal communication, refusing medications, and not acknowledging her status of being in the hospital.

It was noted that when she did talk, she accused her father and the therapist of putting her in the hospital for no reason.

On March 22nd at 2:00 a.m., the recipient's right to refuse medication was restricted because she was (according to chart documentation) pacing the hallways, she was restless, she refused redirection, she was asking the same question over and over, she wanted a snack, and she wanted to stay in the dayroom and listen to music. The note states that one-on-one intervention was given with no result so PRN (as needed) was given and a ROR (Restriction of Rights Notice) was completed. The note did not state that the recipient was given the opportunity to refuse the medication. It was noted that the consumer's treatment plan did not indicate her emergency treatment preference, if any. The chart contained a Restriction of Rights Notice (ROR) for the emergency medication. It was noted that the form did not contain a section regarding emergency intervention preference; and documentation did not indicate whether the consumer was asked if she wished for anyone be notified of the restriction.

According to the record, the recipient was refusing medication based on the belief that she was pregnant, despite many negative tests. On April 17th, it was documented that a meeting was held with the Social Worker, the Director of Nursing, the Psychiatrist and the recipient's father regarding the father as the agent under Power of Attorney (POA) and guardianship status and whether or not a court order was needed for the administration of psychotropic medication. Since the recipient did not want to take medication but the POA disagreed, the Psychiatrist directed the Social Worker to contact the State's Attorney for clarification. It was documented that the recipient was not to be forcibly medicated until an answer was received. The state's attorney responded the same day and said that the form sounded correct. The record showed that when oral medications were refused, intramuscular medication was given. It was noted that Restriction of Rights Notices were not completed. By April 24th, it was documented that the recipient was medication compliant.

It is noted that on April 20th, a RN documented that he reviewed the medication with the recipient prior to administering it. After receiving the medication, it was noted that she requested and received a written hand-out about the medication. Charting did not indicate that the POA/Guardian also received this information.

At the site visit, it was stated that the hospital attorney and the state's attorney agreed that medication can be given to a recipient over his/her objection based on a valid POA. Regarding the claim that staff did not explain the medication to the recipient before it was given, it was stated that staff members are to identify and explain the medication at each dose.

The hospital's Refusal of Medication and Conditions for Emergency Use of Medication policy states that if the consumer refuses medication, the consumer may receive the medication only if the consumer demonstrates behavior that causes serious and imminent physical harm to the consumer and or others and documentation in the medical record notes the need for emergency medication. The policy further states that the RN is responsible for documenting the refusal in the medical record and reviewing the consumer's identified preference for treatment, documents the specifics of the patient's behavior to support the presence of a serious and imminent threat to self/others, notifies the attending psychiatrist and obtains an order to

administer the medication along with rationale, completes a restriction of rights notice and monitors and documents the patient's response to the intervention.

Conclusion

Pursuant to the Mental Health and Developmental Disabilities Code, 5/2-107, a recipient shall be given the opportunity to refuse generally accepted mental health services, including but not limited to medication. If the services are refused, it can only be given in an emergency situation to prevent serious and imminent physical harm to the recipient or other when no less restrictive alternative is available. Pursuant to hospital policy, emergency medication is to be given only when the behavior potentially causes serious and imminent physical harm to the consumer and/ or others and documentation in the medical record supports the need for emergency medication. The HRA finds that the documentation did not justify the need for the emergency medication; the allegation is substantiated. The ROR form did not contain a section regarding emergency intervention preference, and documentation did not indicate whether the consumer wished that anyone be notified of the restriction. This matter has been recently addressed and resolved in another case (#09-100-9024) by the means of a Mental Health Treatment Preference form; this form asks the consumer about his/her emergency intervention preference. The new form was not yet implemented at the time of this hospitalization.

Pursuant to the Probate Act, Section 4-1, "The General Assembly recognizes the right of the individual to control all aspects of his or her personal care and medical treatment, including the right to decline medical treatment or to direct that it be withdrawn, even if death ensues. The right of the individual to decide about personal care overrides the obligation of the physician and other health care providers to render care or to preserve life and health. However, if the individual becomes disabled, her or his right to control treatment may be denied unless the individual, as principal, can delegate the decision making power to a trusted agent and be sure that the agent's power to make personal and health care decisions for the principal will be effective to the same extent as though made by the principal."

Executing a power of attorney does not mean that the individual can no longer make decisions; it just means that another person can act for that individual also. As long as the individual is capable of making decisions, the other person must follow those directions. The HRA was advised by agency counsel that if there is a valid POA, medications can be given pursuant to it, unless the recipient is objecting, an objection to the agent's authority to act should be construed as a revocation of the POA. In this case, the medication should not have been given over the recipient's objection.

Pursuant to Section 5/2-102 of the Mental Health Code, "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. 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. 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 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act may not consent to the administration of electroconvulsive therapy or psychotropic medication. A surrogate may, however, petition for administration of such treatment pursuant to this Act. If the recipient is under guardianship and the guardian is authorized to consent to the administration of electroconvulsive therapy or psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment".

Section 5/2-107 of the Code states that "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. 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. Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition."

Section 2-107.1. 1 of the Code states that "Any person 18 years of age or older, including any guardian, may petition the circuit court for an order authorizing the administration of psychotropic medication and electroconvulsive therapy to a recipient of services. The petition shall state that the petitioner has made a good faith attempt to determine whether the recipient has executed a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act and to obtain copies of these instruments if they exist. If either of the above-named instruments is available to the petitioner, the instrument or a copy of the instrument shall be attached to the petition as an exhibit. The petitioner shall deliver a copy of the petition, and notice of the time and place of the hearing, to the respondent, his or her attorney, any known agent or attorney-in-fact, if any, and the guardian, if any, no later than 3 days prior to the date of the hearing. Service of the petition and notice of the time and place of the hearing may be made by transmitting them via facsimile machine to the respondent or other party. Upon receipt of the petition and notice, the party served, or the person delivering the petition and notice to the party served, shall acknowledge service. If the party sending the petition and notice does not receive acknowledgement of service within 24 hours, service must be made by personal service. The petition may include a request that the court authorize such testing and procedures as may be essential for the safe and effective administration of the psychotropic medication or electroconvulsive therapy sought to be administered, but only where the petition sets forth the

specific testing and procedures sought to be administered. If a hearing is requested to be held immediately following the hearing on a petition for involuntary admission, then the notice requirement shall be the same as that for the hearing on the petition for involuntary admission, and the petition filed pursuant to this Section shall be filed with the petition for involuntary admission." The remainder of this Section sets forth the hearing process.

Recommendations

1) Hospital Administration must instruct all hospital personnel that the record must clearly reflect the emergent need to override treatment refusals - to include the least restrictive alternative considered - in order to prevent serious and imminent physical harm and the Mental Health Code and hospital policy must be followed in those situations.
2) The hospital must ensure that when there is a valid POA, medications can be given pursuant to it. But, if the recipient is objecting, an objection to the agent's authority to act should be construed as a revocation of the POA.
3) The hospital must ensure that Restriction of Rights Notices are completed each time medication is given over the recipient's objection.

Suggestions

1) The hospital must ensure that medication benefits and side-effects are shared with the substitute decision maker.
2) The hospital must ensure that any designated emergency treatment preference per 5/2-200d of the Mental Health Code is noted on respective treatment plans per 5/2-102. And, it is suggested that the hospital ensure that recipients are informed of their right to have *any person or agency* notified of a *any* rights restriction per 2-201, including the right to refuse medications, and not just having family/significant others notified when restrained or secluded (as provided on the Mental Health Treatment Preference Form).

RESPONSE

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

Westlake Hospital
1225 West Lake Street
Melrose Park, Illinois 60160
708.938.7201

Resurrection Health Care

Pat Shehorn
Chief Executive Officer

September 21, 2009

Dan Haligas – Chairperson
Guardianship and Advocacy Commission
911 Harrison Street, W-300
Des Plaines, IL 60016-1565

RE: HRA #09-100-9036

Dear Mr. Haligas:

Westlake Hospital has reviewed the findings from Guardianship and Advocacy Commission and would like its' response made available to the public.

The Inpatient Psychiatric Unit at Westlake Hospital always seeks to be in compliance with the regulatory standards of the Illinois Mental Code as well as standards related to the Power of Attorney and appreciates the opportunity to improve our policies and procedures.

An education plan for the inpatient staff has been developed and implemented with expected completion by October 2009. The unit educator in collaboration with the manager has prepared materials that cover the required elements of documentation in the medical record specific to the use of emergency medications, noting the behaviors that create a serious and imminent physical threat to the patient and/or others, use of least restrictive alternatives, the Restriction of Rights and all rights associated with that document, patient education regarding the reason for the intervention and the expected response, and, a follow-up summary of the patient's response to the intervention.

The unit has verified that we are using the current Restriction of Rights form from the State of Illinois; educated staff on the rights associated with this document and are monitoring compliance of use.

Patients who present with a Power of Attorney document for mental health care are now identified upon admission and reported as such during shift to shift report. The RN is responsible for ensuring compliance with the requirements of this document. Education regarding the appropriate use and revocation of this document is in process and monitoring of compliance is in place.

The unit has implemented use of the document specific to the Mental Health Treatment Preference Declaration Act and monitors compliance with use.

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Mr. Dan Haligas
September 21, 2009
Page 02

Performance improvement measures are in place that will allow us to regularly monitor our compliance with these changes and will be reported at the Department of Psychiatry meeting and the Hospital Performance Improvement Committee on a quarterly basis. Any identified issues will be immediately addressed through staff counseling and additional education, if necessary.

We have recently contracted with the law firm of Joe Monahan to provide a series of educational sessions for the staff of the psychiatric unit. The sessions will address emergency use of medications, completion of the restriction of Rights and appropriate notification of identified persons, the Power of Attorney specific to the delivery of mental health care and the Mental Health Treatment Preference Declaration Act.

We noted your suggestions regarding education of patients on the benefits and side effects of medications and the importance of notification of the substitute decision maker. Your suggestion for documentation of the mental health preference shall be included on the individual treatment plan of the patient, along with notification of person/s of their choosing relating to interventions. We have asked our legal counsel to include these additional elements in their education plan.

Thank you for your feedback as we seek to continuously strive for excellence in the delivery of care.

Sincerely,

Pat Shehorn

PS/ll