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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9011
ROCKFORD MEMORIAL HOSPITAL

Case Summary: Violations were substantiated within complaints #1 and 5. The Authority's findings are recorded below, and the facility response follows.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the treatment of a mental health patient at Rockford Memorial Hospital. Allegations state that the hospital:

1. Administered psychotropic medications without the patient's informed consent.
2. Administered forced psychotropic medications without cause and due process.
3. Had the patient sign admission records without explanation and when her condition was not appropriate.
4. Would not allow the patient to receive telephone calls from persons of her choice.
5. Did not have rights information posted on the behavioral unit.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

Rockford Memorial is a subsidiary of the Rockford Health System. It serves the area with nearly four hundred beds, a Level I Trauma Center/Emergency Department (ED) and a twelve-bed Behavioral Medicine Unit. We visited the facility and discussed the matter with several representatives and with staff who were involved in this patient's care. Relevant policies were reviewed as were sections of the adult patient's medical record with proper authorization.

FINDINGS

Complaint #s 1 and 2: the hospital administered psychotropic medications without the patient's informed consent and administered forced psychotropic medications without cause and due process.

According to administrators and ED staff, the general practice in the ED is not to give psychotropic medications without informed consent; if a patient refuses, the medication is not

given and the refusal would be documented. It remains the physician's final decision on whether to proceed with a restriction if medications are still needed to prevent serious harm. Verbal information about psychotropics is provided at the time they are offered or administered and written information about drug uses and side effects is provided on discharge summaries. We were told that psychotropics are rarely used in that department and that the majority of mental health patients present there with suicidal ideation, depression or just to have prescriptions refilled. There is no ED-specific policy on psychotropic use or restriction processes, but all staff can access "E-policies" online to locate hospital psychiatric policies when needed. In addition, the hospital has recently made psychiatric social workers available to the department 24/7 to assure that due processes are followed. During the day and evening hours they are able to respond within twenty minutes or sooner and at night an on-call social worker can respond within an hour. ED staff were also included in recent Mental Health Code training.

The physician who treated this patient was unavailable during our visit, but we spoke with the attending nurse who administered medications. He said the patient was quite manic and seemed to be mostly cooperative, except for one point during evaluation when she tried to flee. She was coaxed back in, and she agreed to take some medications. The nurse said he explained what the medications were for and how they would help. He asked her whether she preferred an injection in her arm, thigh or rear end, and she chose the latter. He would not have carried out the orders had she refused, and he would have alerted the physician for further directives. Restricting her right to refuse was not necessary in this case.

We looked to the ED record for support. It showed that the patient and her boyfriend arrived late one night with complaints of bizarre behavior and agitation. She was described as being cooperative, alert and oriented to person, place and time; she appeared manic, but in no acute distress. The nurse entered two psychotropic medication administrations: 10 milligrams of Haldol, by injection, at 9:32 p.m. and 2 milligrams of Ativan, by mouth, at 10:30 p.m. The entries stated that the patient was advised of actions and side effects prior to both administrations. A physician noted his attempt to reduce the patient's anxiety with the Haldol. He wrote that she continued to be disorganized and had attempted to flee. There were no documented details on what transpired when she fled, but a petition for involuntary admission and a certificate were completed at 9:00 p.m. and 10:00 p.m. respectively, and the patient was admitted to the Behavioral Medicine Unit.

Regarding the Behavioral Medicine Unit, several nurses and a psychiatrist explained that physicians are responsible for assessing whether a patient has decisional capacity before psychotropic medications are prescribed. Capacity statements are typically documented in the History and Physical report. Nurses are responsible for providing written education on whatever is prescribed, and they fax orders to the pharmacy and give written information to patients as soon as orders are received. The program uses consent forms for prescribed psychotropics that include spaces to document completed education. Evidence of education can be found there and in progress notes. They ask patients for their emergency intervention preferences and document any designations on a risk assessment form, but preferences are not noted on treatment plans. A restricted right to refuse medication would be accompanied by a restriction notice, which would be given to the patient and anyone the patient requests.

The psychiatrist who treated this patient said she always covers medication particulars verbally with patients at the time she proposes them as she did in this case. With authorization, she talks with patients' families about medications as well. She specifically remembered going over everything about Lithium and did not recall the patient objecting or having concerns about taking it; same for the other medications that were ordered. She and the nurses we spoke with remembered the patient being selective, in that she would decide day-to-day whether to take her medications or not. None of them recalled an instance where medications had to be forced on her. At one time she tried to leave the unit. Security was called to help in the situation, but the patient calmed down, was redirectable and agreed to take medications that were offered. The nurse who administered the injection said she would not have proceeded had the patient refused, even with security present.

According to the chart, Lamictal and Ambien were started on November 9th. A consent form notes the patient's competence in choosing these medications as well as the written education provided and includes a physician's and the patient's signatures. Abilify, Haldol and Ativan were started on November 9th too. But the consent forms showed that written education was not provided until November 23rd, and they exclude a decisional capacity statement. Klonopin was started on the 12th and Cogentin on the 13th or 14th, but there is no documented evidence of getting informed consent at all. Lithium was started on the 14th, and again the consent form along with noted written education was not completed until the 23rd. Progress notes and the History and Physical report do not mention the patient's decisional capacity.

There was one situation described in progress notes that potentially involved the use of forced medications and help from security. The November 9th nursing entry stated that the patient tried to leave the unit with her boyfriend and ran at the doors; she was blocked by the boyfriend and the nurse. She was noted to be resistive as additional staff joined to prevent her from getting through, and security was called for assistance. The entry ended by stating that Ativan and Haldol injections were given with security present but that the patient was cooperative. There were no restriction notices in the record, and subsequent progress notes point to the patient's frequent compliance and occasional requests for medications.

CONCLUSION

Rockford Memorial policy on the rights of patients on the psychiatric unit (#32) lists the Mental Health Code's process for obtaining informed consent for psychotropic medication use (405 ILCS 5/2-102 a-5). Each patient has the right to participate in treatment planning, to designate preferences for emergency intervention, and to be informed in writing about proposed medications. The program's emergency involuntary treatment policy (#36) is a near verbatim outline of the Code as well (405 ILCS 5/2-107), and it includes all Code-required steps to determine and document the need to prevent serious and imminent harm, to provide adult patients and any guardian or substitute decision maker the opportunity to refuse medications and to ensure that no less restrictive alternatives are available first. Its rights restriction policy (#34) likewise follows the Code (405 ILCS 5/2-201) and calls for written notification whenever a patient's right is restricted. Notices are promptly forwarded to the patient, any guardian and anyone designated by the patient.

Under the Mental Health Code,

If the services include the administration of…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 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…. 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).

Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction…and the reason therefor to:
(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;
(3) the facility director;
(4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985, if either is so designated; and
(5) the recipient's substitute decision maker, if any. (405 ILCS 5/2-201 a).

In this case there is documented evidence of nurses or physicians providing verbal explanations about psychotropics as they were offered in the ED and on the Behavioral Medicine Unit. The same information that is required to be given in writing as required by hospital policy and the Code is missing from the ED and when six psychotropics were started on the unit. Although the patient seemed willing to take them, her consent was accepted without first determining her decisional capacity and without providing her chance to fully consider the side effects, risks, benefits and alternatives. Complaint #1 is a <u>substantiated</u> violation. There was one incident in the record where it is unclear if the patient had a choice in taking two injections. That documentation concluded that the patient was cooperative, and the administering nurse who administered them assured us that the patient had a choice and that the medications were not forced. There is no indication otherwise. Complaint #2 is <u>not substantiated</u>.

RECOMMENDATIONS

1. Require all prescribing physicians to determine and state in writing whether patients have the capacity to make reasoned decisions about all proposed psychotropic medications (405 ILCS 5/2-102 a-5), and determine where these statements are to be documented in records.
2. Secure *informed* consent by providing written education on every psychotropic medication as they are prescribed, including new ones that follow initial orders (405 ILCS 5/2-102 a-5).

SUGGESTIONS

1. Capacity should be determined and documented at the time psychotropic medications are proposed (405 ILCS 5/2-102 a-5). We suggest that capacity statements be included on consent forms. If physicians are not handling consent forms, then the statements should be included within a physician's initial assessment/treatment plan notes where orders are first noted.
2. With only twelve beds, conduct chart audits specifically for consents and restrictions on a regular basis.
3. Require Behavioral Medicine Unit staff to note all patients' stated emergency intervention preferences in their respective treatment plans (405 ILCS 5/2-200d, 5/2-102 a, and RMH Policy 2060 #3).
4. Be certain that psychotropic education materials used at Rockford Memorial include alternatives to the proposed treatments (405 ILCS 5/2-102 a-5).

Complaint #3: the hospital had the patient sign admission records without explanation and when her condition was inappropriate.

Nurses from the unit described the typical admission process and the types of information and materials that are provided. In addition to covering the gamut of recipient rights, nurses have initial assessments to complete and they orient the patient to the unit and the program: rules, schedules, consents etc. Patients who cannot make it through the admission process because of their conditions are usually visited at a later time to go over the information again, finish whatever was incomplete and have any questions answered.

The admitting nurse for this patient remembered the situation and said she was able to cover rights information and some other admission items although the patient said she was tired. Asked to clarify, she said the patient may have been tired but was alert enough to take the rights information in, and they went ahead and finished everything later. She was not sure exactly when.

We looked to the admission note from the patient's record. The nurse wrote just after midnight that the new patient was very sleepy, tearful, and had a hard time keeping her eyes open as she had Haldol and Ativan injections in the ED. It was noted that the patient was admitted involuntarily and that those related rights along with general recipient rights were read

and copies were given to her; exchange of those documents were verified by the nurse's and the patient's signatures. It was also noted that the patient was only able to sign a few consents because she was too tired and that they would have to complete the process in the morning. Another entry at 5:45 a.m. referenced the nurse's second attempt to finish the admission. She noted that the History and Physical was completed in addition to the rest of the "admission papers". There is no mention that rights materials from the night before were covered again.

CONCLUSION

Unit intake policy (2060 #6) states that it is the hospital's intention to provide intake procedures that are thorough in informational content, consistent with the patient's rights and are conducted in a careful and caring manner. Upon receipt of involuntary forms, the admitting nurse will notify the psychiatrist of the patient's arrival to obtain orders for treatment, conduct an interview with the patient in private, explain the nature of the unit and the goals of treatment, explain property and clothing issues, explain routines, and review copies of written rights information. Admitting nurses are to document that the patient has received verbal and written rights information. The patient is asked to sign an authorization for treatment form and releases of information as needed, and the nurse completes an admission assessment.

Provided in the Mental Health Code, *Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient…shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program.* (405 ILCS 5/2-200 a). For involuntary admissions the Code adds, *Within 12 hours after the admission of a person to a mental health facility under Article VI [certification] or Article VII [court order] 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.*

Here the question is whether the patient was asked to sign various forms during admission without explanation of what they were and when she was in no condition to comprehend the contents. Forms like treatment and release authorizations and orientation to the program are required under hospital policies. Important legal forms such as the two types of rights information shared with involuntary patients, "Rights of Admittee" and "MHDD-1 [Rights of Individuals Receiving Mental Health…Services]" are required under the policies and the Code. We are skeptical about the patient's alertness during admission when she was described as very sleepy and having a hard time keeping her eyes open after 10 milligrams of Haldol and 2 milligrams of Ativan. But the nurse recalled that she was in fact alert enough to go over the rights information; she was able to sign the recipient rights form, and thankfully the nurse decided to finish the other admission papers later that morning, which included releases and restraint/seclusion education notices. Based on the nurse's statement and her documentation, the complaint is not substantiated.

SUGGESTION

1. Since rights materials are so important, be sure to ask patients if they would like to go over them again if they were tired or unable to complete the admission process before.

Complaint #4: the hospital would not allow the patient to receive telephone calls from persons of her choice.

We were told that patient telephones are on from early morning until 10:30 p.m. except when groups are in session during the day. They are located in visiting/common spaces across from the nurses' station but not within earshot. Every patient has private access to them unless it is necessary to prevent harm or harassment, in which case a restriction notice would be completed. The unit staff said there were no restrictions on this patient's calls, incoming or outgoing.

The patient's record contained no restriction notices. While telephone calls are not tracked, visitors are, and visitor sign-in sheets listed numerous people including her boyfriend, and aunt, her parents and a couple friends, all of whom appeared many times throughout her stay. Progress notes reflected multiple visits from them too, sometimes for family group sessions and sometimes for general visits. On November 13th the staff were concerned about how the patient became agitated after her visitors left and were encouraging them to limit their numbers to just a couple instead of six or seven. There was also an incident that day when the patient wanted to call the police saying she was being held illegally, and she was not prevented from contacting 911 or the Guardianship and Advocacy Commission. No restrictions followed regarding visits or calls. A couple days later she was quoted as saying she did not want her boyfriend visiting that day and that she would call and tell him. According to a subsequent entry, the boyfriend appeared anyway, and after a contentious visit the patient wanted him to leave. A notation on the 18th stated that the patient was upset. She called 911 again and security was up to tell her not to call there; there was no restriction placed on her telephone use. The following day she was noted to say that she decided not have her boyfriend visit for two days and that she would call to tell him. Her psychiatrist encouraged her to consider at least taking twenty-four hours off from talking with the boyfriend as that might help her progress, but there were no restrictions from the telephone. Another entry that day reflects how the patient's father called to say her aunt should not visit for a while given her own issues. There were numerous references about having more visitors, another reference about the patient "being on the phone a lot", but no incidents where she had to be restricted from making or receiving calls through her discharge.

CONCLUSION

The program's telephone policy (2060 #05) states that patients will have access to a shared phone when they are not engaged in group sessions or other therapeutic activities. Their right to use the phone can be restricted by the attending psychiatrist or a charge nurse if necessary to prevent harm, harassment or intimidation.

The Code states nearly the same,

> *Except as provided in this Section, a recipient who resides in a mental health…facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. ....*

Reasonable times and places for the use of telephones and for visits may be established in writing by the facility director. Unimpeded, private and uncensored communication by mail, telephone, and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation…. (405 ILCS 5/2-103).

This complaint stated that the patient was not allowed to receive calls from persons of her choice, but according to the staff and their documentation, the patient was appropriately encouraged to limit the number of people visiting at one time and encouraged to try talking less with her boyfriend to help in her progress. She was not prohibited from making or receiving calls as far as the documentation goes. The complaint is not substantiated.

Complaint #5: the hospital did not have rights information posted on the behavioral unit.

This writer visited the facility and saw no recipient rights information displayed and the staff on duty at the time could not explain why. The hospital's attorney responded that a manic patient had been there and tore things off the walls, which was why there were no postings. He offered that a rights document was now up in a more permanent, secure location. The HRA toured the facility during this review and verified the posting.

CONCLUSION

Per the Mental Health Code, *Every facility shall…post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility.* (405 ILCS 5/2-200 a).

A violation is substantiated, and has been remedied.

RESPONSE

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

Rockford Memorial Hospital

2400 North Rockton Avenue
Rockford, IL 61103
(815) 971-5000

ROCKFORD HEALTH system
Respectful Care

February 3, 2011

Florence Sandberg, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main Street, Ste. #108
Rockford, IL 61103-5202

Re: #10-080-9011

Dear Ms. Sandberg:

Please accept our thanks to the Guardianship and Advocacy Commission for taking the time to meet with us on several occasions to provide feedback and insight on ways we can improve the behavioral health services furnished at Rockford Memorial Hospital, part of Rockford Health System. At Rockford Health System, our goal is to provide our patients with Respectful Care, and compliance with the Illinois Mental Health and Developmental Disabilities Code and its patient rights mandates is an essential element to achieving this mission.

In response to the recommended action items outlined in your January 19, 2011 report, please note that all of the action items have been completed as described below.

Case Number 10-080-9011
Recommendations

1. Require all prescribing physicians to determine and state in writing whether patients have the capacity to make reasoned decisions about all proposed psychotropic medications (405 ILCS 5/2-102 a-5), and determine where these statements are to be documented in the record.

   Response: To strive for the best care for our patients, Rockford Memorial Hospital maintains that assessment of a patient's capacity to consent to treatment is continuous. Upon initial assessment by the psychiatrist, the psychiatrist will notate in the patient's Treatment Plan the patient's capacity to consent to treatment. The psychiatrist will also assess the patient's capacity to consent to treatment upon each clinical encounter with patient and will notate any changes to the patient's capacity to consent to treatment within the progress notes of the medical record. If there is a change to the patient's capacity to consent to treatment, the nurse caring for the patient will be

notified by the psychiatrist, and the patient's Treatment Plan will be modified accordingly.

2. Secure informed consent by providing written education on every psychotropic medication as they are prescribed, including new ones that follow initial orders (405 ILCS 5/2-102 -5).

   Response: To help ensure informed consent is obtained by our patients, both clinical and management staff have received education and training on the informed consent process, and have the necessary tools to provide patients with written information regarding prescribed medications, as well as alternative medications available.

Again, we appreciate the time you have taken to help us with our mission of providing Respectful Care to each and every patient we serve.

Sincerely,

Dan Parod
Sr. Vice President of Hospital and Administrative Affairs