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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9014 AND 10-080-9015
ROCKFORD MEMORIAL HOSPITAL

Case Summary: Findings were cited on all complaints except for the petitioning issue. The facility's response immediately follows.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of potential rights violations within the psychiatric unit at Rockford Memorial Hospital. In case #10-080-9014 it was alleged that the unit's manager orders staff to hide medications in patients' food and drink. In case #10-080-9015 it was alleged that the unit's manager has directed staff to change dates on petitions and certificates, to prohibit an attorney from access to a patient client, and to listen in on patient telephone conversations. Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

A subsidiary of the Rockford Health System, Rockford Memorial has nearly four hundred beds, twelve of which make up the adult psychiatric unit. We visited the hospital on two occasions where the issues were discussed with representatives from administration, legal and psychiatry. Interviews were held separately with twelve psychiatric unit employees, and four additional employees who were unable to attend completed our questionnaires. Related policies were reviewed as were sections of five patient records with identifiable information redacted.

The HRA expresses appreciation for the attention and cooperation shown at Rockford Memorial Hospital throughout this investigation.

COMPLAINT SUMMARIES

The allegation in #9014 states that the unit manager directed staff to put psychotropic medication in a patient's food or drink, saying to be sure the dose was not documented because it was illegal. Complaints in #9015 claim that the manager tampers with dates on petitions and certificates, falsifying them, and has told the staff to change dates on them when they are incorrect or late. An attorney called to speak with a patient client on the unit one day and was told her client was not available when he actually was; the manager reportedly said to tell the

attorney he was unavailable to avoid upsetting him. Last, a physician and the manager were confronting difficult issues with a patient who wanted to make a phone call. The manager allegedly told a staff person to listen in on the patient's conversation.

FINDINGS

#10-080-9014

Hospital administrators confirmed during our first visit that indeed, there was an instance when psychotropic medication was hidden in a patient's food and drink. The unit manager informed her superior the day after it happened and explained what occurred. The patient was a large, intimidating man who consistently made physical and sexually inappropriate gestures toward the female staff to the point they felt threatened and unsafe; the unit was eventually closed to new patients because of his presence. There was an incident where security guards and added help were unable to contain him. Contrary to the complaint, a nurse got verbal orders from a physician, not the manager, to put medication in the patient's soda, and later on, it was put in his ice cream. We were told that although he had previously consented to and was educated on the medication he would sometimes refuse to take it as in this case. He was never informed of the hidden doses, was not given a rights restriction notice and has long since been discharged. An administrator said she met with the physician and made it clear how unacceptable this was and that he was genuine in seeing the error.

In separate interviews, the manager said she learned one weekend that the patient was back for a second admission. She alerted the nursing office and security for extra help given his aggressive and dangerous behaviors the first time around. On Sunday there were three people on shift with security visiting periodically. She called for an update and a nurse reported that the patient was doing well after she put meds in his soda per a physician's directive. The manager told her that was wrong and not to repeat it. She notified her superior the next morning who said the physician was already in her office and that the matter was being addressed. The manager finished by saying she was unaware of the second dose hidden in the patient's ice cream until the investigation began but that both doses were documented as given in the patient's record. She denied telling anyone to avoid documenting because it was illegal. We are unable to verify that without a release. The physician said he was thinking of everyone's safety when he gave a verbal order to put the medicine in the patient's drink if he refused to take it. The patient weighed over two hundred pounds and was extremely violent; nurses and even security were afraid of him. At one point an ambulance driver and emergency department staff came up to help but without much success. The physician understood the mistake and said there had been recent training on medication and rights issues.

We followed up with ten additional employee interviews. Most were aware of the incident but were not there when it happened, and most of them knew of no other occurrence outside of helping patients with swallowing problems. The charge nurse who followed the order described the situation and said that the patient was escalating, controlling the unit. The staff were frightened and she called for more security and backup, but seven to eight people on site

were still unable to calm him. The physician arrived and told her to put the medicine in a drink, so she did. The nurse who hid the second dose said that she got to work in the evening and was told by the charge nurse that this was fine to do per the physician and the manager. She commented that the unit needed better staffing ratios. According to a third nurse, she heard the physician say this was done before, but she was not aware of any other situation. A fourth nurse said that on Monday she came in for morning report and listened to the first charge nurse explain what took place the day before and how the manager told her not to document the doses because it was highly illegal, which would have been tape recorded. The fourth nurse also said that she and other employees remarked to the physician about the patient's rights and how unlawful this was. She added that per the physician, the manager said she was fine with doing it. We noted several discrepancies about these responses: the charge nurse told the manager about the hidden medication soon after it was given; the manager said she told her not to do it again; the evening nurse who hid the second dose said the charge nurse told her it was ok per the physician and the manager, and another nurse said the physician told her it was ok per the manager. We asked the hospital for clarification and whether the tape recording included directives not to chart the medications. Through its attorney, the hospital said it preferred to focus on compliance rather than discipline and that it would be unproductive to come to any final conclusion as to the precise unfolding of events.

The hospital's legal team informed the HRA that an extensive in-house investigation and staff training on legal matters were conducted immediately. They provided copies of training materials that revealed topics such as informed consent, rights, rights restriction and medication procedures. Sign-in sheets reflected numerous employees including physicians who attended these trainings, and the training has been extended to emergency department and security personnel as well.

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.

The HRA has relied solely on personnel statements to account for this incident, all of which, including those from nurses on the unit at the time of the incident, consistently attest to the idea that this patient created a dangerous scene and needed intervention. According to their recollections, he refused to take medications and numerous attempts at redirection by several

people were unsuccessful. The staff and other patients on the unit were said to remain fearful of him, and, thinking of safety, a physician decided to put medication in the patient's drink as a last resort. In that case, the hospital failed to protect the patient's rights when being medicated without his consent, more accurately, without his knowledge. Per the Mental Health Code and hospital policies he should have been given an opportunity to refuse those doses, there should have been documented follow up with him and he should have been given an opportunity to seek help in reviewing his rights restriction. Most disturbingly, he has never been informed of what he ingested. A rights violation is substantiated. Given the hospital's preference not to clarify the interview discrepancies or whether the tape recording is more revealing, the answers seem obvious. And, given the fact that the hospital reacted to this complaint with responsibility and by providing extensive training to all unit staff including physicians and the ED, the HRA is satisfied that the situation has been thoroughly addressed.

RECOMMENDATIONS

1. Base staffing levels on acuity as opposed to census to ensure a culture of safety for everyone.
2. Develop a behavioral safety code (code999) and policy to ensure that adequate and appropriately trained staff arrive to assist with a behavioral health patient on any unit.

SUGGESTIONS

1. Rights (#32) and involuntary treatment (#36) policies refer to psychotropic medications as authorized involuntary treatment, which is outdated. The policies should be updated to match the Code's current language and to save any confusion if these policies are used as staff training tools.
2. The involuntary treatment policy (#36) should also be updated to reflect in item K that emergency continuances beyond 72 hours on filed petitions must still comply with subsections a, b and c of Section 5/2-107.

#10-080-9015

Regarding complaints that the manager tampers with dates on petitions and certificates and directs staff to make changes on them, hospital administrators said they found no evidence from their reviews to imply any wrongdoing. They were aware of one incident for example, when a petition was done over to satisfy a receiving hospital's complaints about the original one but that Rockford Memorial was the original petitioner and provided nothing less than factual on the re-do.

We included this complaint in our interviews with the staff, most of whom said they have completed petitions at some point and have made minor corrections when needed like making sure they are completed thoroughly, putting in times, checking appropriate boxes, and adding family information and the right dates. Not one of them provided examples of what could be

considered tampering or falsifying and not one of them said they had been directed to do that. Two staff members recalled a similar situation where a receiving hospital returned a petition, saying they were uncomfortable with the date which looked to be changed from the 22nd to the 23rd; the staff said that the manager sent the hospital a new one. A third staff member referenced the same example on his questionnaire. In a separate interview, the manager remembered the incident as well and said that she was the petitioner. The receiving hospital wanted a little more information about the patient and did not like how she wrote her 2s and 5s so she completed and sent a new one.

Five records with identifiable information redacted were provided for our review. We looked specifically at the placement of petitions and certificates during each patient's stay. Although there were numerous technical errors within them, there appeared to be no indication that the documents had been tampered or falsified.

Hospital administrators said that they also found no evidence to suggest that attorneys have been prevented from reaching their clients or that staff have listened in on patient phone conversations. But our interviews resulted differently. According to an attorney who represents many Rockford Memorial patients, she often finds it difficult to reach her clients on both patient phones although she knows they are turned off when groups are in session. She said that about ninety percent of the time when she tries to reach them through the staff phone she is told the clients are in group or they are sleeping--any time of day, and she is told to call back. Some clients have told her they were never informed that she called for them. A social worker said she remembered a recent situation when a patient called Guardianship and Advocacy several times one day but had trouble getting through. Someone from the agency called back for him and the manager said to say he was in group. A nurse described another instance where a patient was sitting in his room when his attorney called for him. The manager told her not to get him riled up and to say he was in group. The same nurse also recalled a time when a physician and the manager were dealing with a particular patient who wanted to make a phone call. The manager told her to listen in on the patient's conversation and let them know if there were any concerns, which she reluctantly did. We followed up with the physician who said he had no recollection. We also followed up with the manager who explained what she remembered about both situations. Regarding the attorney's call, she said she made a mistake and thought the patient was in group but discovered soon after he was not, and she handed him a note to return the call. About the eavesdropping on a phone call, she said there was a patient who was threatening her family over the phone and the family wanted it stopped. She did not tell the staff to listen in, but rather to get a sense of the "flavor of the conversation, which you can hear without listening."

After these interviews and some discussion on attorney access, the hospital agreed to implement a new procedure whereby patients will decide whether to take calls from their attorneys during groups. As we understand, attorneys are to be informed that group is in session first, and if he or she persists, the patient will be alerted.

CONCLUSION

The program's admission under petition and certificate policy (#31) instructs that all petitions must be completed with required details and be signed and dated, which falls in line with the Mental Health Code (405 ILCS 5/3-601). The Code adds that knowingly making a material false statement in a petition is a Class A misdemeanor (405 ILCS 5/3-601) and that every petition and certificate shall be executed under penalty of perjury as though under oath or affirmation (405 ILCS 5/3-203). Its rights policy (#32) states that patients have the right to unimpeded, private and uncensored communication with persons of their choice by mail, telephone and visitation, which is provided for in the Code (405 ILCS 5/2-103). An access to phones policy (#30) states that a patient's phone use may be restricted if necessary to prevent harm, harassment or intimidation, also provided for in the Code (405 ILCS 5/2-103). According to this policy, patients will not be permitted to accept phone calls during regularly scheduled activities such as group meetings, individual therapy, or planned activities. As mentioned earlier, the hospital's rights restriction policy (#34) 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. That is established in the Code as well (405 ILCS 5/2-201). A visitor's policy (#22) states that any attorney who represents a patient shall be permitted unrestricted access during normal business hours unless the patient refuses, just as it does in the Code (405 ILCS 5/2-103), but there is no mention of how attorney phone calls are to be handled. Under the Code, counsel shall not be prevented from conferring with a client at reasonable times (405 ILCS 5/3-805).

Neither Rockford Memorial nor the HRA found evidence that petitions or certificates have been tampered with inappropriately or falsified; that part of the complaint is not substantiated. At least one staff person recounted an incident where an attorney was prevented from reaching her client, and although the manager described the situation as a mistake, the patient nonetheless missed his call; the complaint is a substantiated Code violation. Since the manager said she gave the patient a note once she realized the error, the incident seemed to be handled immediately and appropriately. One staff person also recounted another situation where she was instructed by the manager to listen in on a patient's phone conversation. Although the manager explained that it was necessary to monitor for threats she had been making, listening in any way to a patient's phone conversation is not private and is therefore, a rights violation under the Code and hospital policy. In addition, if it was indeed necessary to monitor the call, the patient's right to a notified restriction should have been protected with documented reasoning and the opportunity to have the restriction reviewed by anyone of her choice per the Code and hospital policy. The complaint is substantiated.

RECOMMENDATIONS

1. Develop written policy on the new procedures for attorney phone calls.
2. Train all unit staff on the new policy unless this has already been covered in recent trainings.

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

October 28, 2010

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

Re: #10-080-9014 and 10-080-9015

Dear Ms. Sandberg:

On behalf of the Guardianship and Advocacy Commission, please accept our thanks 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 October 13, 2010 reports please note that all of the action items have been completed as described below.

Case Number 10-080-9014
Recommendations

1. Base staffing levels on acuity as opposed to census to ensure a culture of safety for everyone.
   Response: We have implemented two methods of addressing this concern: i) we have established an Admission Criteria for our Emergency Department staff to help facilitate communication between the Emergency Department and the Behavioral Health Unit; and ii) we are assessing our patient care needs on a daily basis, and staffing appropriately to address these needs. We have hired Cawley Johnson, an independent management group, to help us improve our staffing solutions.
2. Develop a behavioral safety code (code999) and policy to ensure that adequate and appropriately trained staff arrives to assist with a behavioral health patient on any unit.
   Response: We are finalizing the establishment of a code with the Quality Department and the Patient Safety Officer, which we expect to implement yet this year.

Case Number 10-080-9015
Recommendations

1. Develop written policy on the new procedures for attorney phone calls.
   Response: We have updated all policies, with the assistance of Joseph T. Monahan, Esq., to reflect the appropriate language from the Mental Health Code.
2. Train all unit staff on the new policy unless this has already been covered in recent trainings.
   Response: All staff have been trained on these changes. Our goal is to provide ongoing training to the Behavioral Health Unit by providing real life examples and having open discussions to ensure best practices. By doing so, we hope to continue to promote the understanding of the technical requirements under the Illinois Mental Health Code and create a secure environment for our patients and staff.

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

Dan Parod
Sr. Vice President of Hospital and Administrative Affairs